

NURSING HOMES, HOSPITALS AND MEDICAID:

REIMBURSEMENT POLICY ADJUSTMENTS

1981-1982

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**NURSING HOMES, HOSPITALS AND MEDICAID:
REIMBURSEMENT POLICY ADJUSTMENTS**

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**Information
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Introduction

The purpose of this study is to investigate the effects of various factors on the growth and development of the human body. The study will focus on the relationship between nutrition, exercise, and sleep, and how these factors influence the overall health and well-being of individuals. The research will be conducted through a series of experiments and observations, with data being collected and analyzed to draw conclusions about the impact of these factors on human growth. The study will also explore the role of genetics in determining the potential for growth and development, and how environmental factors can influence the expression of these genetic traits. The findings of this study will be valuable for understanding the complex process of human growth and development, and for developing strategies to optimize health and well-being.

EXECUTIVE SUMMARY

The abrupt reduction in the current and projected federal funding of health care for Medicaid clients and other economically disadvantaged individuals has prompted a great deal of concern by states, providers and clients. Initially, many had expected that reductions in federal revenues would result in a wholesale reduction in benefit coverage for Medicaid clients and increased stringency in the states' definitions for eligibility. While that has occurred in some instances, it has not been the most prominent aspect of change. The most notable feature of the states' responses to limited funds has been the enormous diversity and inventiveness of new policies and procedures. In particular, reimbursement mechanisms for hospitals and nursing homes have undergone dramatic change during the past two years. A national survey conducted by the National Governors' Association for this study has documented the nature and extent of these changes. Further changes in Medicaid hospital reimbursement will be generated by the recent shift to a Medicare reimbursement methodology based on diagnosis-related group (DRG) categories. This issue is not examined in this report, which was prepared prior to passage of that legislation.

The reimbursement of hospitals and nursing homes is a very important issue for the states. First, reimbursement practices tend to be one of the most powerful policy tools that the states use. Second, nursing homes and hospitals are the largest expenditure item in the Medicaid program. These institutions account for three-fourths of Medicaid's total expenditures. They have been among the most rapidly increasing expenditures and represent the most expensive form of care available on a per unit basis. Effective control of Medicaid can only exist when there is effective control over institutions.

It appears that states are beginning to gain that control. A number of factors have contributed to this change: increased federal cooperation and statutory authority, increased state fiscal pressure and greater technical sophistication.

While nursing homes and hospitals are very different institutions, there have been converging trends in the reimbursement of both types of institutions. States have tended to opt for prospective payment mechanisms for both, to develop a rate or price for services within categories of institutions (rather than allowing reimbursement to rise with the costs incurred by each specific institution) and to employ case mix adjusted reimbursement approaches.

Our survey findings indicate that states have become acutely aware of the different needs and functions of high volume Medicaid hospitals vis-a-vis all other hospitals. Further, states are assessing all forms of state and local subsidies used to support high volume Medicaid hospitals. Alternative reimbursement systems frequently provide for preferential treatment of the high volume hospitals by either increasing their relative reimbursement rate or allowing them to receive special assistance through an emergency cash flow fund.

Two of the most significant developments in nursing home reimbursement have been the case mix adjustments made by eight states and the treatment of capital. In both areas a number of solutions have been designed to cope with problems that seemed intractable only a few years ago.

This paper reviews a national profile of reimbursement activity, based upon a survey conducted by NGA for this paper, and the specific reimbursement experience in selected states. Recommendations are made for improvements that states can make in their nursing home and hospital reimbursement programs.

I. INTRODUCTION

The Medicaid program finances a wide range of services for the poor, but a preponderant share of program resources goes for payments for institutional care. In 1979, 75 percent of Medicaid's total expenditures, or \$15.1 billion of \$20.5 billion, was spent on services provided by nursing homes and hospitals. However, the ability of state Medicaid programs to continue to finance an adequate supply of institutional services is being challenged by new limitations on federal funding, state fiscal difficulties, and growing welfare rolls. The problem is compounded by the shifting of responsibility for other federally funded programs onto states and localities and the increased burdens that are being borne by major high volume Medicaid institutions such as public and teaching hospitals.

Despite proposals for federal assumption of the Medicaid program, states will have to administer and financially contribute to their Medicaid programs for at least two more years. The ability of these state programs to provide needed services will depend upon the effectiveness of current and future cost containment efforts. In turn, institutional reimbursement policies and procedures represent one of the most powerful methods for affecting provider behavior, reducing expenditures and increasing the efficiency of Medicaid programs.

This paper examines the reimbursement trends and innovations that have occurred within states in the past two years. It not only provides a national profile of activity but reviews specific state efforts to modify and improve nursing home and hospital reimbursement and suggests methods for states to improve their programs.

II. MEDICAID IN TRANSITION

In federal fiscal year 1982, total federal and state expenditures grew by only 9.8 percent. This annual rate of growth was half the annual rate of increases in expenditures for the past two years and the lowest since the inception of the program. Moreover, this reduction in Medicaid took place during a period when rates of increase for Medicare and the medical component of the Consumer Price Index remained relatively unaltered. Something is happening in Medicaid. A major factor which has contributed to the tighter control that states seem to have over their Medicaid programs is the dramatic change in the treatment of institutions. Control over Medicaid expenditures necessitates control over institutional expenditures or wholesale reductions in the eligible population. In 1979, hospitals and nursing homes represented 77.8 percent of total expenditures. Between 1973 and 1979, institutional expenditures increased at an average annual rate of 19.0 percent. Physician services, prescription drugs and other non-institutional goods and services accounted for 22.2 percent of total expenditures and increased at an average annual rate of 10.9 percent between 1973 and 1979. Given the recession and the increase in the rolls, the broad options to contain Medicaid costs have been limited to one: containing the growth in institutional costs.

Between 1980 and 1982 that is exactly what appears to have happened. Except for ICF-MRs*, the annual rate of growth for expenditures on institutions ranged from 9 percent for ICFs to 13 percent for hospitals. The Medicaid program as a whole increased at 13.5 percent per year during this period.¹ Three sets of actions appear to have affected institutional expenditures:

1. Reductions in rates of increase per unit cost² (typically cost per day or admission) have incurred in a number of states.² The ability for states to impose more stringent controls over hospital reimbursement than allowed under Medicare's "reasonable cost" reimbursement required a federally

*ICF-MRs remain the exception. The expenditures increased at a rate of 35 percent. Given the peculiar position ICF-MRs maintain vis-a-vis state mental health departments, Medicaid and the federal government, it is unlikely that ICF-MRs will be affected by the cutbacks in a similar way that other institutions are.

approved alternative "reasonable cost" reimbursement methodology. In December 1980, 10 states had approved alternative payment mechanisms. States responded rapidly to the increased flexibility given them in the 1981 amendments to federal law. By June 1982, 18 states had alternative payment mechanisms in place, and three other states were seriously considering adopting them. Eight of the ten states with the largest Medicaid budgets in the country employed alternative hospital reimbursement systems. Another intriguing aspect of the change is that 6 of the 8 states to adopt new approaches between December 1980 and June 1982 were southern states (Alabama, Florida, Georgia, Kentucky, Mississippi, and North Carolina).

Changes in nursing home reimbursement are more difficult to track. This is due in part to the fact that the majority of the states have not adopted one method for reimbursement for nursing homes whereas 32 states continue to employ Medicare's reimbursement methodology for hospitals. In comparison to hospitals, states have had fewer federal constraints placed on their reimbursement of nursing homes. Fewer constraints coupled with the sensitive nature of Medicaid's relationship with nursing homes has also contributed to rapid "turnover" in regulations and payment mechanisms in many states; as one state official quipped, "the half life of nursing home regulation is six months at most." Still there are some indications that reimbursement methodologies for nursing homes have become more stringent in the past few years. For example, between 1979 and 1980, the average increase in SNF, ICF and ICF-MR per diem payments was 13.4, 12.3 and 20.7 percent, respectively. Between 1980 and 1981 that rate of increase dropped to 11.5 for SNFs, 11.3 for ICFs and 17.5 for ICF-MRs. States increasingly have closed loopholes around problematic aspects of nursing home reimbursement such as capital costs, management fees and administrative salaries by narrowing definitions of allowable costs, freezing costs at historic levels, imputing fees or setting screens that were outside the possible manipulation of all but the largest chains. Finally, another example which is only suggestive of the direction the states are moving is the record of Medicaid changes compiled in the National Governors' Association's Catalogue of State Medicaid Program Changes. Between 1978 and 1982, the states reported 310 proposed and adopted reimbursement changes for SNFs and ICFs. Less than a fifth of those changes would have increased rates, nearly all the remaining changes would have reduced rates. Again, since the listings vary in detail, complexity and impact, they are not conclusive. Given other indicators, however, these changes appear to accurately reflect a direction towards greater control.

2. Medicaid agencies are attempting to eliminate or reduce the rate of increase in institutional capacity. This has assumed a wide variety of forms and has involved tying reimbursement to limits on beds or patient days. The recently enacted California legislation which permits a health czar to negotiate essentially exclusive service contracts with hospitals in a region may reduce state payments for excess capacity in the hospital industry (i.e., by directing Medicaid patients to fewer hospitals, the occupancy rates in those hospitals increase and the state's payments for unused beds decline). States are also attempting to control the growth of beds by refusing to pay for new beds. In Tennessee, for example, any nursing home bed which was not under construction by October 1981 has no assurance that the state will certify the bed for Medicaid clients (regardless of whether or not it meets certification standards). A non-certified bed of course will not be reimbursed. In Pennsylvania any nursing home bed constructed after 1981 will not receive any payment for

property costs. A recent interpretation by the Kansas City Regional Office informed the state of Missouri that it could limit certified beds if such a limit was consistent with state planning requirements. In other states, facility-specific limits have been developed for the number of patient days the state will recognize and reimburse. For example, Illinois projects the expected volume of Medicaid days for each hospital participating in the program, allows a hospital to change the projection but then uses the mutually agreed-upon amount of days to fix volume and set per diem reimbursement for each hospital. In North Carolina, hospitals whose per diem costs exceed the 60th percentile of all participating hospitals will be reimbursed their full costs for a limited number of total Medicaid days. Specifically, high cost hospitals will receive Medicare's reasonable cost reimbursement as long as the number of days they provide does not exceed 85 percent of the total days of care they provided in the previous year. Thereafter, they will receive a per diem rate equal to the 60th percentile.

Of course, the most common approach to limiting days for reimbursement is to cut back coverage of care. For the most part, this tactic has been limited to hospitals. In 1981 and 1982, 11 states changed their coverage of hospital days: 2 increased coverage, 9 decreased it. There are several problems with this approach to cost containment. It imposes a penalty upon those who need the service the most, creates an excessive burden for high volume Medicaid hospitals and in some cases actually increases rather than decreases costs. For example, Tennessee recently decreased its coverage of hospital days from 21 to 14. In the first six months of that policy, the average length of stay increased by one day. Since the state did not experience an epidemic during that period, there are at least two possible explanations. Physicians and hospital administrators screened applicants and selectively admitted those with the more severe and acute diagnosis. If this occurred, it would have meant that the hospitals were indifferent to the losses that they might incur (i.e. the likelihood of a patient staying in the hospital beyond the 14th day increases with increases in the severity and complexity of the case). On the other hand, if the admitting practices remained unaltered, the institutions might have attempted to compensate for expected losses with complicated cases by keeping the short stay uncomplicated cases much longer. If that was the case, the state would have incurred greater hospital costs by reducing coverage to 14 days.

3. States are engaging in increased efforts to control costs related to unnecessary admissions. For long term care, a growing number of states are applying pre-admission screening to Medicaid as well as private pay patients. This and other prior approval controls have decreased the facilities' discretion on their admissions policies and they are no longer able to restrict admissions to light care patients. Pre-admission screening does not necessarily reduce costs. If there is a sufficient queue of Medicaid patients, it is very likely that the state will not realize a reduction in the number of beds filled but that the nursing homes will realize a noticeable increase in heavy care, high cost patients. In fact, it appears that nationally between 1973 and 1977 there was in fact an increase in the level of disability among patients in nursing homes.

If the rates do not reflect the increased costs required to care for some of these heavily debilitated patients and if the light care low cost patients are diverted away from the homes, facilities will be unable to engage in their own internal cross subsidization (where the surplus earned on the low cost patients

offsets the losses incurred on the high cost patients). The net result is that the sickest patients who could be appropriately placed in nursing homes may be unable to find placement in a long-term care facility. These patients will either back up in hospitals or make do as well as they can in their own homes. While preadmission screening may result in a slight increase in debility, we would also expect a smaller variation around the average level of debility.

In order to deal with these and other problems related to reimbursement systems which do not pay on the basis of the patients' needs, a number of states developed patient-based payment mechanisms. Some are very limited with specific goals. For example, Massachusetts will pay 120 percent of its SNF rate for one year to a nursing home which will accept a patient who has incurred 150 or more administratively necessary days in a hospital. The following year the rate drops to 110 percent and then to the SNF rate. Utah negotiates patient specific nursing home rates for heavy care hospitalized patients. In Ohio, Illinois, West Virginia, Washington and Maryland, detailed and sophisticated patient evaluations and patient cost schemes are in place.

Control over hospital admissions have been primarily limited to utilization controls such as second opinion programs or prior authorization for elective procedures. Reimbursement policy linked to admissions has consisted either of limiting days of coverage according to diagnosis (as is done in Arkansas) or paying a flat fee according to diagnosis (as is the case in the New Jersey DRG demonstration). In the first instance there is a strong incentive to accept the healthiest patients within a diagnostic category and to keep them hospitalized for the maximum reimbursable days. In the DRG instance, there is also an incentive to admit healthier patients but in this case hospitals maximize their return by discharging the patients from the hospitals as quickly as possible. In either case, hospitals increase revenues by increasing the admissions of desirable patients and shifting the others onto other hospitals. It should be stressed, however, that if the state sets sufficiently stringent limits on lengths of stay or cost per stay, there will be reduced admissions by hospitals which are able to turn away patients.

Reductions in rate of increase in per unit costs, capacity and admissions can and are having an important effect upon the program and reimbursement methodologies. The level of activity and the diversity of the changes being imposed may, however, obscure another important trend.

Many states are approaching the limits of traditional cost shifting techniques. The Medicaid cutbacks which simply reduce eligibility standards or benefit coverage or resulted in temporary pro-rata reductions in provider rates are acceptable if there is some slack in the delivery system or welfare programs to absorb the displaced recipients or uncovered costs. The Reagan Administration's reduction in support for health and social programs has not only eliminated much of the slack, it has also resulted in a large number

of competing groups vying for whatever excess capacity or unclaimed resources remain. Those who quietly absorbed the cost of state cost shifting strategies in the past are no longer quiet. Cities and counties complain about the increased burden of caring for the recently disenfranchised poor. Commercial carriers have initiated an aggressive lobbying effort against the cost shifting encouraged by cost based reimbursement and government cutbacks. Providers who grudgingly accommodated cutbacks through internal cross-subsidies are finding that approach increasingly untenable and are turning the poor away. All of this has contributed to a political environment which is unstable and has required more global and inventive approaches. In response to this many states are currently preparing or attempting to restructure the delivery of care for Medicaid recipients. It is happening in both acute care and in long term care. Actual arrangements again differ greatly within and between states. The new organizations developing to provide health care fall under a host of different generic titles (everything from public consortiums and provider cartels to primary care networks and social health maintenance organizations). These new structures tend, however, to have four common characteristics:

1. Provider participation is limited
2. Client use of participating providers is constrained
3. The state's financial liability is limited
4. Case-management is an integral part of the systems.

The case management aspect warrants further elaboration. The case manager is typically a primary care physician for acute services or a social worker or nurse practitioner for long term care services. Case management serves to improve the capacity of the organizations, to target care to appropriate individuals, direct clients to the least expensive setting for care, introduce concern for efficiency and the cost of services at the delivery level, and to monitor the quality of care.

While only a few states have implemented statewide alternatives to fee-for-service (e.g., the primary care networks in Utah and Colorado, and the Arizona statewide

demonstrations), many are engaging in large regional projects (e.g., Massachusetts, New York, New Jersey, Kentucky, Tennessee, Michigan, Ohio, and Pennsylvania). But equally important, the changes being made in reimbursement policy are acting to set the stage for alternatives. Thus the redesign of the hospital reimbursement system not only permit those states to leverage immediate savings off the existing system but can also develop the groundwork for restructuring the hospital industry (through statewide rate setting) or restructuring the Medicaid delivery system.

All of these changes will be reviewed in much greater detail below. But of immediate interest are some of the reasons states have been able to gain apparent control over the programs and why so many programs are embarking on large scale attempts to restructure the delivery mechanisms.

1. The Omnibus Reconciliation Act of 1981 was important legislation. It freed the states of many unwieldy federal restrictions and encouraged innovation. What was equally important, however, is that the 1981 legislation was a manifestation of the Administration's "new flexibility" and "competition" rhetoric which translated into what might be termed a "rare" cooperative federal posture. Federal agencies have engaged in rapid review and approval of changes in state plans and waiver requests. How long this will continue is not clear. Further, the interpretation of the 1982 tax law by HCFA and the courts is of course a factor that will have a strong impact upon federal-state relationships. Through September 1982, however, the federal government has given the states greater leeway and encouraged more innovation than has been the case for a number of years.
2. The states' fiscal crises have improved the states' ability to negotiate and receive provider cooperation. The shortfall in state revenues, the cuts in Federal funds, the resistance to new taxes, the increased demands for state services to aid the unemployed and poor have become a familiar chorus in

many states. Much in accordance with Thomas Schelling's suggestion, states find themselves painted into very tight corners. Clients know it and providers believe it. They understand that the circumstances could result in drastic and irrational behavior from state government. In order to prevent disaster, providers in particular are willing to yield to the least objectionable alternatives--alternatives they would not even have entertained a few years ago--or to suggest and develop alternatives. Certainly, the Michigan State Medical Society would not have developed the primary care sponsor program jointly with the state Department of Social Services if the Medical Society had not been prevailed upon formally by the Michigan Legislature to come up with an alternative to save money or have some implied but unnamed solution imposed upon them. Similarly, the Boston teaching hospitals and neighborhood health centers would never have formed a corporation to provide care for all AFDC clients in Boston if Governor King had not embarked on an effort to offset the losses incurred by localities (compliments of Proposition 2½) through savings in the Medicaid program, savings which would be produced through a privately managed, statewide fixed price contract.

3. Medicaid is a mature program which has developed sophisticated management skills, engaged in innovative experiments and demonstrations and has recently been marked by rapid dissemination of information via the detailed surveys and reports of the National Governors' Association, the Intergovernmental Health Policy Project, and the frequent regional and national Medicaid Directors' conferences. Many of the Medicaid directors have been able and willing to employ innovative solutions. The times have finally permitted that application on a large scale.

Given all of this, we shall now examine the Medicaid program trends by means of a detailed review of two of Medicaid's most powerful policy instruments: nursing home and

hospital reimbursement procedures. In each case we shall examine national trends, present case studies and make recommendations.

III. NURSING HOME REIMBURSEMENT

A. National Trends

Medicaid nursing home reimbursement systems exhibit considerable variety in their form and content. Fortunately the variability is constrained and some common characteristics exist across states. State-by-state reimbursement policy characteristics are given in Appendix B and reimbursement rate data are given in Appendix C. In 1981, the national average daily rate reimbursed to a SNF for a Medicaid patient was \$41.77; of this approximately \$32.00 was paid by the state, the remaining amount by the patient. Between 1979 and 1981 the rates increased at a yearly average of 11.6 percent. The highest average daily payments in 1981 for SNF care (outside of Alaska and Hawaii) were in New York (\$67.63), New Mexico (\$66.31) and Maine (\$61.15). The lowest per diem rates were in Arkansas (\$25.53), South Dakota (\$26.36) and Kansas (\$27.80). Most states reimbursed SNFs on a prospective basis. Twenty-five employed prospective facility-specific mechanisms and five prospective class rates. Thirteen states used retrospective facility-specific systems. Six states employed a combination of prospective and retrospective components in their systems.

Intermediate care facilities were paid an average statewide per diem of \$33.49 in 1981. The highest average daily ICF payments (again exclusive of Alaska and Hawaii) were in the District of Columbia (\$50.87), Delaware (\$44.28) and New York (\$42.74). The lowest level of reimbursement was in Kansas (\$22.16), Nebraska (\$22.57) and Illinois (\$22.84). Between 1979 and 1982, the rates increased at an average annual rate of 11.8%. A larger number of states used prospective systems for ICFs than SNFs. Twenty-eight states employed a prospective facility-specific approach and five used a prospective class rate system. Five states used a retrospective facility-specific methodology. Six states used some combination of the retrospective and prospective approaches.

Finally, ICF-MRs were the most expensive form of long term care outside of a hospital setting. The average per diem payment in 1981 was \$66.64. The highest payments were made in Alaska (\$167.00), Massachusetts (\$123.00), Michigan (\$118.00) and

Maryland (\$114.95); the lowest in Illinois (\$24.62), Washington (\$34.37) and Mississippi (\$38.94). Between 1979 and 1981 rates increased an average of 18.6 percent per year. Twenty-six states reimbursed on a prospective basis (23 facility-specific and 3 class rate), 16 on a retrospective basis and 6 on a combination of retrospective and prospective components.

These general characteristics prompt several observations. First, there is enormous variation in rates for all levels of care, even though each level of care ostensibly is providing comparable care to comparable patients. Thus, there is nearly a \$30 per diem difference between the highest and lowest average ICF state rates. The highest rate is more than twice the lowest. ICF-MRs represent the most extreme situation. Nearly \$100 per day separates the lowest from the highest rate for ICF-MRs. The highest rate is five times the lowest. What is equally puzzling are differences within regions. In New England, for example, average state Medicaid payments for ICF care ranged from \$40.68 in New Hampshire, \$37.05 in Maine and \$35.65 in Vermont to \$29.15 in Massachusetts and \$26.57 in Connecticut.

Second, while most states employ prospective systems, their use varies significantly depending upon whether the homes are SNFs and ICFs or ICF-MRs. Thus, while 30 or more states reimburse SNFs or ICFs on a prospective basis, only 26 states use this approach for ICF-MRs. What is more telling, however, is the portion of total nursing home expenditures represented by states using prospective systems. States representing 78 percent of national expenditures use prospective systems for SNFs; those with 73 percent of the expenditures use prospective systems for ICFs and those with only 52 percent of national expenditures use prospective systems for ICF-MRs. There are a number of reasons for this discrepancy: the relatively higher incidence of antiquated bookkeeping practices among ICF-MRs than SNF and ICFs may have made it more difficult to develop prospective systems for ICF-MRs. The nature of ICF-MR patients and the role that ICF-MRs have played in the deinstitutionalization process may have

prompted states to retain a payment mechanism which encouraged expansion. Equally compelling, however, is the large number of state- or county-operated ICF-MRs in certain states. There is less of an incentive for a state to impose payment systems upon itself which penalizes inefficiency. Further, state and county ICF-MRs often substitute state and federal money for services that had previously been funded by 100 percent state money in state institutions.

Two recent surveys conducted by NGA permit a review of states in much more detail than just a broad classification of reimbursement systems.* There are five components of reimbursement methodologies which are of special interest and importance: capital reimbursements, peer groupings of homes, inflation indices, application of cost limits and case mix adjustments. We have selected these components because they have been politically sensitive issues, legally contended and unresolved, administratively difficult to implement and/or technically complex. State action in these areas has been varied and often inventive. Further, compared to the early and mid-1970s when a number of special state commissions decried abuses and called for reform, many states have in fact closed loopholes, reformed practices and solved some pressing problems. In order to examine that process more closely, we shall examine each of these areas.

B. Capital Reimbursement

States appear to be setting multiple limits on capital, to be restricting the control that owners and operators have over the manipulation of property costs and to be effectively approaching reimbursement methodologies which pay a "fair rental value" or "fee-for-capital." The fee-for-capital option resolves the problems--both real and imagined--with trafficking (the sale and re-sale of a home solely to maximize Medicaid reimbursement), leaseback arrangements, and other real estate manipulations. By setting one fee or modified fees based on the age and size of the facility, the state frees itself

*Those surveys are summarized in Appendix B and C.

from monitoring and ruling upon the reasonableness of private transactions. The fee-for-capital approach is apparent in systems like Utah's, where one unmodifiable fee is assigned to a home's property costs--regardless of sale or leasing. That fee remains unchanged. It is also apparent in the West Virginia system where a per patient day rate limit on depreciation interest or leases is based on multiple regressions adjusted for differences in the age and type of home. It is also becoming a part of the Georgia system which is developing a fee based on the age and square footage per bed.

A system for a fee-for-capital can also develop when reimbursement for the discretionary behavior of owners and operators is restricted. This is accomplished through limits on reimbursable costs per bed, the use of the lower of multiple screens to set the value of a home, limits on sales prices, depreciation recapture provisions, incentives not to sell and limits on leases.

Set dollar limits on currently 13 states the costs of beds. The cost restrictions range from \$17,900 per bed in Indiana to \$39,900 per private bed (or \$26,500 per bed in rooms with two or more beds) in Minnesota. These states usually inflate the value of the beds to reflect changes in the market and construction. Some states are even more restrictive. In Massachusetts, for example, the value of nursing home beds are frozen at their 1976 rate. In Connecticut only historic costs from the date of construction are costs used to calculate costs.

Where states have not frozen the reimbursable value of a home, they have often limited the recognizable costs to the lower of purchase price, depreciated replacement costs, market value and/or state dollar maximums per bed. Virginia, Pennsylvania, Rhode Island, Florida and Michigan use this approach. In addition, Michigan only recognizes one property transaction every five years.

North Carolina, Kentucky and several other states cap property costs by using the normative standards within the industry. Kentucky, for example, uses 105 percent of the median costs for property as the maximum the state will pay.

Six of the 45 states responding to the NGA questionnaire on nursing home reimbursement did not recognize the sale of a home. Of the 39 which did, the majority placed limits on the sale, through the use of multiple screens (e.g., depreciated replacement costs, appraised value or purchase price), depreciation recapture provisions (where the state "recaptures" or requires repayment for all or a portion of reimbursed depreciation if the purchase price exceeds historic costs of the property) or incentives not to sell (usually structured as a decreasing depreciation recapture requirement with each additional year of ownership).

Similarly, while 39 states reimbursed lease expenses, 24 set limitations on those payments. Those limitations typically restricted reimbursement to what the owner of the facility would have received in terms of allowable depreciation and interest expenses.

Reimbursement of profits and a return on equity also reflect increased state control. Fourteen states do not reimburse either profits or a return on equity, eight reimburse only profits, 16 only a return on equity and 11 reimburse both profits and a return on equity. Reimbursement for profits, however, in the 20 of the 21 states recognizing profits is only on a variable fee per patient day up to a maximum. First, profits are paid only if the home performs at a cost below some state maximum. Second, the amount of profits are inversely related to the costs incurred by the home--the lower total costs the greater the profits up to a maximum amount. Finally, the homes receive only a portion (usually 25 to 50 percent) of the difference between their actual costs and the higher maximum allowable costs.

C. Peer Groupings

The case of classification of homes for reimbursement purposes defines comparability. It is frequently assumed that comparable homes should have comparable costs and further that the normative behavior of comparable homes is the desirable behavior (i.e., if most homes operate at \$38.00 or less per day, then \$38.00 defines the maximum amount that an efficient and economic home will be reimbursed). Problems with this approach

develop when large unexplained variations in costs exist and persist between homes within peer groups in a specific state and between homes in comparable states within a region. The problems signify either the inappropriate selection of distinguishing features, inappropriate application of normative standards, or persistence of important factors not addressed in the peer groupings. It should be stressed that states often have sound and justifiable reasons for omitting certain factors from a grouping scheme.

One of the more unusual aspects of the reimbursement process is that many states may not have selected the most appropriate characteristics for grouping homes. In Appendix C, 36 of 49 states use the federally designated levels of care (e.g., SNF and ICF) for classifying homes. Yet the SNF/ICF distinction may be unwarranted. First, as noted above, there are enormous variations in the rates paid to SNFs and ICFs within and between states, a fact which alone strains the comparability thesis. Second, there is enormous variation in the percentage of SNF and ICF beds among states. For example, in 1979, California spent only 5 percent of its SNF/ICF budget on ICFs. The remaining 95 percent was allocated to SNFs. In Iowa in the same year, ICFs received 98 percent of the SNF/ICF budget. SNFs received less than 2 percent. It is unlikely that variation reflects the needs of the elderly population within those states. The next two most frequent factors used to group homes are the bed size of the facility and whether or not the beds are free-standing or hospital based. Bed size is clearly a legitimate factor if the size of the facility has an impact on cost and if the state artificially restricts the size of homes through certificate of need or some other regulatory process. If the state does not restrict the size of a facility, however, a state should carefully examine whether it should reward facilities for being too large or too small.

In a similar vein, eight states make reimbursement distinctions according to whether a facility is free-standing or hospital based. This distinction is made in part because hospital based facilities' costs are inflated by hospital accounting conventions and in part because hospital based beds supposedly are more susceptible to admitting sicker patients

than free-standing facilities. Again, it is not entirely clear whether a program for the poor should support expensive accounting customs which apportion a disproportionate amount of high fixed costs of the hospital to nursing home beds. It is equally unclear whether the state should assume severe case mix in hospital based beds when a more efficient approach would be to gear the reimbursement system to directly recognize case mix differences in patients (see pages 19-33 below).

Five states group homes according to whether they are public, non-profit and/or proprietary. The rationale for such a distinction is that ownership is either a strong proxy for either quality (with ostensibly higher quality care in public and non-profit homes) or for casemix (with public homes allegedly acting as a receptacle for the hard-to-care-for, expensive patients.) A number of studies conducted by different states (e.g., New York, Wisconsin and Minnesota) have failed to corroborate either of those assertions.⁴ What has been established, however, is that public and voluntary homes are more expensive than proprietary homes. If quality or casemix are unrelated to that higher cost, it is not apparent that the states should support those costs. Even if those cost differences are related, there are more efficient and effective ways of defining quality of care and casemix and reimbursing accordingly.

Two of the most reasonable factors to use in the construction of peer groups would seem to be geographic location (as a proxy for regional differences in labor and supplies) and case mix as a measure of differences in patient needs and requirements. Currently, 5 states use location to group homes and 8 states attempt to link reimbursement with case mix either for the extremely sick patient (Utah or Massachusetts), on a sample basis (Illinois) or on an entire patient census (Ohio).

D. Inflation Indices

The Consumer Price Index (CPI) does not accurately measure the inflation faced by nursing homes. The CPI is a highly volatile index which may distort the actual economic

Table 1
RATES OF INFLATION

	<u>1979</u>	<u>1980</u>	<u>1981</u>
CPI	11.3%	13.5%	10.3%
GNP-Deflator	8.7	9.3	9.4
HCFA Nursing Home Input Price Index	9.0	9.9	10.0

environment faced by homes. The inclusion of current mortgage rates, the restriction to only consumer products and the fixed weighted distribution of goods and services have made the CPI a highly inflationary index compared to the GNP Deflator or the HCFA Nursing Home Input Price Index. The GNP Deflator uses increases in rents rather than mortgage rates, includes changes in prices in all sectors (consumer goods, government, and investor and producer goods), and has a changing composition to reflect changes in the output of the economy. The HCFA Nursing Home Input Price Index is derived from detailed BLS analysis of more than 15 percent of the nursing homes in the country. It is explicitly designed to measure the cost increases of the market basket of goods and services actually purchased by nursing homes. As can be seen in Table 1 CPI rates during 1979 through 1981 were one to four percentage points higher than the GNP deflator and as much as 3.6 percentage points higher than the HCFA Index.⁵

Given that 50 to 60 percent of the increased expenditures in nursing homes is due to inflation, the selection of an inappropriate index can have very costly implications. And yet 27 states somehow incorporate the CPI in calculating trend factors, and 15 of these states use the CPIs exclusively. Nineteen states use composite indices designed by the state (which may include a CPI component). Three states use the HCFA index (Alabama, Rhode Island and Wisconsin). Only one state, Connecticut, uses the GNP deflator.

E. Cost Limits

Not surprisingly, most states placed limits on the per diem costs paid to nursing homes. Nine limited total costs only, 12 limited cost centers and 19 limited both total

costs and cost centers. Percentile limits were used most frequently. Percentile limits again reflect a reliance on normative standards.

Sometimes states have attempted to use cost ceilings to attain minimum expenditures by nursing homes for certain items essential to patient well-being. For example, one state considered setting much higher ceilings on food and nursing as a way of encouraging homes to provide minimum amounts of both services. That policy may encourage some homes to increase expenditures but it may also result in excessive costs and it certainly does not require a home to increase such expenditures. If a state wishes to have a minimum amount spent on food, nursing care or whatever, then requirements might be considered relative to the minimum amount and not an increased maximum.

F. Case Mix Adjustments

Eight states are currently paying according to case mix or service needs of the patients: Illinois, West Virginia, Ohio, Washington, Maryland, New York, Massachusetts and Utah. The techniques employed vary considerably. Some states receive monthly status reports from the home, others review the patients with state staff on a quarterly or yearly basis. Some measure each patient's needs. Others take a sample of patients and apply a case mix factor to the home, while others assign a higher rate only to hospitalized patients needing nursing home care. Assessment devices and cost allocations differ although use of the Activities of Daily Living (ADL) is an integral part of five state programs, and special recognition of specific services is part of four programs.

The following briefly reviews the methodologies used by eight states. Where information was available, some analysis of the impact of the systems as well as implementation problems encountered are also reviewed.

1. Illinois

In 1967 Illinois adopted a method of payment which assigned a dollar value to the cost of providing care to patients with specific needs. The methodology set forth a number of different needs and disabilities. As the level of disability became more severe,

the points assigned to it increased and the amount paid increased accordingly. For example, a patient received no points if he could move about independently, two points if he could move about with some staff assistance and three points if he was totally immobile and must be moved by staff. While this approach was innovative, the design of the point system had several shortcomings. The most important was that the points were not based on any empirical studies nor was the industry involved in recommending how the points might be assigned. As a result, the relationship between the point based reimbursement and the actual cost of providing care was at best rough.

The point system has undergone a series of changes since its inception. In 1978, the state used regression analysis to establish the cost of points as based solely on the provision of direct patient care. It should be understood that this more sophisticated approach towards determining the cost of a point did not insure that the point system encouraged the most appropriate services. The new procedure was partly in response to the federal mandate to make the system "reasonably cost related" and partly to the state's desire to be able to offer a tighter justification for what it paid. Illinois assumed that the point system recognized differences in patient debility and thereby offset the incentives under other cost-related systems to cream-skim the healthiest patients. A further advantage was the point system's focus on nursing care, the largest cost center most likely to affect the quality of care.

Thomas Walsh and Mike Koetting formerly of the Illinois Department of Public Health argued that the point system was not without problems. They noted four:

- a. It was administratively complex and costly. It required that patients be frequently re-evaluated at a cost to Illinois of \$4 million a year.
- b. Discretion on the part of caseworkers produced discrepancy in patient classification. It was open to the individual shortcomings of caseworkers as to consistency in the application of point count standards, to arbitrary or capricious disregard of those standards and to bribery of nursing home owners

to increase points. In addition, there was a systematic and unexplainable variation of 15 percent among the average point scores of regions within the state. The state remedied this problem by establishing a monitoring system which flagged caseworkers, offices and regions which deviated from expected point count patterns. Perhaps just bringing the problem to the attention of DPH was sufficient. Because of these actions and the greater reliability of current data, interregional differences in the point count no longer existed in 1978.

- c. Simple patient assessment techniques like the point count system "cannot capture all of the needs which can be expected to affect costs of operation. In this case, those patients whose needs are not well represented will have difficulty finding placement. The solution to this objection is obviously to expand the assessment tool. However, the more complex the tool, the greater the administrative expense and possibly the greater the degree of judgement required by caseworkers in evaluating patients."
- d. There were questions as to how consistent the relationships of points were to each other in the assignment of levels of disability and the costs associated with those disabilities. If feeding a bedridden patient costs \$2.00, but the points for that level of disability produced revenue of \$2.50 a day, then the incentive was to keep the patient in bed. On the other hand, if a patient requiring daily colostomy irrigation cost \$6.00 a day and produced revenue of \$5.00 a day, then the incentive was to not accept patients with those needs or provide the service less frequently than was necessary. Thus, if the cost for performing a given service deviated from the revenue generated by the points, then the system tended to either reward homes for keeping patients sick rather than curing them or for denying patients necessary services because of insufficient payment.⁶

It was not clear how strong the cumulative incentive to let a patient deteriorate was under the point count system nor how that general incentive might be thwarted by assigning different points to different levels of disability. Nor was the level of "preference" for certain disabilities clearly understood. If the points were seriously out of line, then they might bias nursing home behavior in a direction inconsistent with public policy.

The assumption, however, that the point count system necessarily provided a disincentive for improving patient condition was not supported nor disputed by empirical studies and must be examined carefully. The fact remained, however, that the points assigned for specific conditions and services were neither based on observations nor broad consensus. The possible improper weighting of services remained the major weakness of the Illinois system.

In order to overcome the problems with the point system the state convened a special committee to revamp its approach to reimbursement. Patient needs were divided into those defined as functional (bathing, clothing, eating, mobility, continence, behavior and orientation) and service needs (appliances, catheterization, diets, douche/enema, dressings, injections, I.V.s, lab/specimens, language rehabilitation, medications, meds monitoring, occupational rehabilitation, ostomy care, physical rehabilitation, respiratory therapy, restorative, social rehabilitation, special health monitoring, suctioning and tube feeding). A panel of long term care nurses and administrators determined the number of minutes required each day to meet each of these needs and the skill level required. The costs associated with providing specific care is then calculated by multiplying the amount of time required times the adjusted wage for a given skill level. In addition, costs associated with a certain amount of time deemed "fixed time" (time attributed to "tidying up residents' rooms, talking to residents and transcribing doctors' orders") is added to each patient's nursing costs.

This new approach became effective in geriatric facilities as of December 31, 1981. Unlike the old point system which required a monthly assessment by caseworkers of all residents, the new system requires that public health nurses review a 50 percent sample* of the patients once every six months. That sample is used to calculate an average cost per patient in the home for the subsequent six month period. This approach improves the quality of the assessment, does away with the charge that the system has an incentive to let specific patients deteriorate, reduces administrative costs and evidently is easier to understand than its predecessor. As a further bonus, expenditures in 1982 were approximately the same as what they would have been under the old point system although some redistribution of payments is expected among homes (with 59 percent of the homes expected to gain and 27 percent expected to lose under the new system).⁹

2. West Virginia

While Illinois may have been the first state attempt to reflect patient needs in the reimbursement system, West Virginia was actually the first state to assign dollar values to those services based upon professional judgement and consensus. In many ways West Virginia has also served as a model for the new Ohio and Illinois systems as well as for other states opting for a patient-based reimbursement approach.⁷

In West Virginia, when a Medicaid patient is admitted or readmitted to a nursing home, there is a prior approval evaluation in nine areas of need (medications, mobility, personal hygiene, feeding, continence, mental and behavior problems, rehabilitation services, special disabilities and special treatments). During the patient's stay in the home, he is also reviewed at least annually by a physician-led multi-disciplinary team. Patient care evaluations are required for a "patient assessment/billing form" which is completed and submitted by the nursing home each month. This assessment/invoice evaluates the patients in sixteen categories of need (medications mobility, personal hygiene, eating, incontinence, behavioral mental status, injections, catheters, dressings,

*In small homes or homes with less than 50 Medicaid residents, all residents are assessed.

enemas/douches, appliances, suction tracheostomy, oxygen, colostomy-ileostomy-ureterostomy, intravenous and subcutaneous fluids, and restorative nursing services). Each category is defined and the gradation of the services required are listed and the documentation necessary to certify that the services were provided is attached. For example, the following would apply to injections:

Injections:

Standard: Any medication introduced by needle, subcutaneous or intramuscular, ordered by a physician and administered by a licensed nurse (R.N. or L.P.N.).

Documentations: The medication sheet must specify the date and time of administration and the signature of the person administering the injection.

Service Values:

- A. No service.
- B. One to twenty-five injections per month.
- C. Twenty-six or more per month.

Each service value is assigned a skill level necessary to perform the task (i.e., either a nurses aide, LPN or RN). The skill level is multiplied by a time factor which reflects the value of the service necessary to perform the task and the frequency of service within a 24-hour period. Both components are combined to arrive at the relative value points. The cost for each service value related to wage rates is assigned to a patient and then summed to give the total payment for direct care.

As the regulations note: -

Allowable costs of nursing services are determined by the kind and amount of services needed by and delivered to the patients. This information which is derived from the patient assessment forms

completed at the facilities is then compared against reported costs and staffing patterns to establish an upper limit for the facilities' nursing cost standard.

(The) nursing cost standard is the average need level of the facility per patient day with necessary adjustments calculated. This average is then compared to the reported allowable cost per patient day and the facility is reimbursed the lesser of the two.

Nursing supplies are also related to patients' assessments; i.e., a higher level of patient need warrants a higher cost for nursing supplies.

West Virginia's system has several advantages. The definitions of need are clearly delineated and distinctions between levels of need are set apart by objective measurements. The West Virginia patient evaluations rely upon both an interdisciplinary medical team and the nursing home's ongoing evaluation and documentation of need and services. Finally, the individual time and cost estimates for services are relatively current and based on broad professional consensus.

However, as with most approaches, there remain a number of questions about West Virginia's system. First, there is a great deal of documentation required. Some of this may be excessive, some insufficient, some easily subject to provider manipulation and all of it difficult to match with the patient's condition, if the patient is evaluated by an independent agency only once a year. Furthermore, the system provides for a quarterly review and validation with recovery based on relative value points for each service not documented.

Under current operation, the reimbursement system may not offer incentives or disincentives for certain types of services. The system design has a restorative service component with financial inducements to restore and maintain patients at their highest level of independency and self-sufficiency.

Finally, there is a question as to how transferable the West Virginia system is. West Virginia is, after all, a small state with a nursing home industry consisting of 89 facilities and approximately 8000 beds. The complexity of West Virginia's approach might make it impractical in other states.

3. Ohio

The Ohio patient assessment system was introduced in 1980. It is an attempt at refinement and extension of West Virginia's methodology. Ohio employs 14 of the same categories of service. Of the two remaining categories, the first, catheters, is incorporated into other Ohio categories and, the second, restorative nursing services is expanded into 6 categories – habilitation, special nursing, physical therapy, speech and audio therapy, occupational therapy and psychological therapy. As within the West Virginia approach, each standard is subdivided into three or four service units representing a frequency or range of services delivered. For example, under the standard, "Intravenous/Subcutaneous Fluid" a patient may be described as needing a) no service, b) 1-48 therapy hours, c) 49-96 therapy hours and, d) more than 96 therapy hours. In this particular instance, the service units are objective and unambiguous, although the initial decision as to how much care a patient will need will require a judgment on the part of the state's review team.

Each service unit is then assigned a dollar value based on three factors:

- a. The time required to deliver the service as determined by a special time study. Ohio has performed a detailed time study of 600 patients in six nursing homes determined by state officials to offer quality care. One hundred to four hundred observations were recorded for most service units;
- b. A weighting factor which includes indirect costs (ranging from nurse participation in physician rounds to coffee breaks and sick leave) and public policy incentives (such as encouraging the home to maintain the patient at his highest level of independence);

- c. Wages for the skill level required to provide the designated service unit.

The assignment of costs for assistance in eating (see Table 2) offers an example of how incentives within the system are intended to operate. The service units are listed in order of patient debility. Because the state has a preference for keeping the patient from tube feeding as long as possible, it has provided the homes with an incentive to maintain spoon feeding for marginal patients through the weighting factor (that is, the home receives a larger bonus in excess of expected costs if it spoon feeds a patient than if it assists a patient to eat or engages in tube feeding of a patient).

The dollar values for each of the service units required by each of the patients are added up and then summed for all patients. This sets the ceiling on state expenditures for all patients in the home. The state then will pay only actual costs up to the ceiling.

Initially, the actual assessment of patients (and the determination of required service units) was to be done by a team of two registered nurses on a quarterly basis. A physician and a social worker were supposed to supplement the review at least once a year. The review was to consist of a visual examination of each patient to identify discrepancies between the observed patient's condition and the patient's condition as reflected in the plan of care and written documentation. This information would have allowed the state to generate reports which would have been used to monitor and analyze changes in the nursing home population and industry performance. The reports would permit the state to monitor the types of services needed and services actually delivered to each patient in every participating nursing home. They would provide a detailed facility profile which indicates not only what services were provided or not provided but which also indicates whether patients received unnecessary services. The state would then have been able to identify labor needs and utilization within each home for RNs, LPNs, Aides and Therapists. Finally, this information would have allowed a basis for comparison between facilities by generating a report which indicates statewide

Table 2

ASSIGNMENT OF COSTS FOR ASSISTANCE IN EATING

Standard: The provision of necessary assistance and supervision to patients for the intake of food, fluids, and sustenance for adequate nourishment. This standard includes N-G tube feedings prescribed by a physician and provided by and RN, or gastrostomy tube feedings prescribed by a physician and provided by an RN or an LPN under the supervision of a registered nurse.

Service Units:

- A. Independent – No Service
- B. Assistance and Supervision

The patient required supervision and some assistance from a staff member; e.g., cutting meat, buttering bread, opening cartons, pouring milk on cereal or cream in coffee with frequent encouragement or reminders from the staff for maintenance of a proper diet. This standard also includes appliances used to assist individual in eating, and routine daily living skills provided as reinforcement or continuation of a daily living training programs.

- C. Spoon Feed

Applies to the patient that is totally fed by a staff member; he cannot bring food to his mouth independently. This category includes the patient who can occasionally bring food to his mouth in an effective manner.

- D. Gastric Tube/Gastrostomy Feedings

Patient is fed as prescribed diet via a naso-oral-gavage tube. This category includes the insertion of the N-G tube by an RN. Care of the gastrostomy opening or feeding through the tube by an RN or an LPN under the supervision of an RN is also included in this category.

Relative Value Scale:

<u>Service</u>	<u>Level</u>	<u>Dollar</u>	<u>- Time</u>	<u>+ Weighting</u>	<u>x Wage</u>
A			-		
B	Aide	\$1.42	14	7	\$4.05
C	Aide	\$6.48	74	32	\$4.05
D	RN	\$7.67	39	20	\$7.80

Source: Ohio Department of Public Welfare.

performance in general and by level of care. The progression from the individual patients to the industry as a whole, would have greatly increased the state's ability to judge, control and improve performance within the nursing homes.

Control in the system however, relies heavily on incentives built into the reimbursement methodology. In addition to the incentives for rehabilitation and maintenance of function, Ohio has three other important incentives.

- a. Unnecessary Institutionalization. The patient reviews will not only identify individuals who do not need to be in a nursing home but will result in a reimbursement rate that is lower than the cost necessary to keep a nursing home bed licensed and certified. This should encourage the homes to discharge the patient. Further, those patients identified as not needing nursing home care are referred to the local Welfare Office for placement elsewhere, and the county may lose the federal portion of the Medicaid payment if it does not act promptly.
- b. Undelivered Services. The Ohio patient assessments will identify whether the services required by the patient were actually delivered. If a necessary services was not provided, the imputed dollar value of that service is subtracted from costs which were incurred by the facility on behalf of Medicaid patients and which would have been reimbursed by the state.
- c. Unnecessary Services. If services are provided, which were not ordered by the patient's physician or indicated by the patient's plan of care, then the state will not pay for those services.

All of the state's intentions and all of the incentives in the system depend upon adequate staffing of nurse assessors. If the assessments are inadequate or not timely, incentives will be distorted. Patient assessments may fail to reflect changes in the patient's characteristics. Cost limitations cannot be applied because the state failed to

follow its own rule for limiting these costs. Penalties for undelivered services cannot be imposed. Incentives for deinstitutionalization become severely weakened.

In fact, the biggest problem has been the lack of staff. This has led to a failure to perform timely assessment for all patients and a buildup of a backlog of patient reviews. Inadequate staffing has been the product of major state fiscal problems which produced two hiring freezes since the implementation of the new system. There has also been a relatively high attrition rate among the nurse assessors. These two factors have combined to produce a major backlog in six out of sixteen regions in the state. A recent concerted effort by the state resulted in updating the homes in the six areas through most of 1981. In order to do this, however, the state waived a review of costs in homes whose costs were five percent below the ceiling and engaged in an abbreviated form of patient review.

In addition to staffing problems, there were methodological problems. Changes are needed in recordkeeping and documentation. Thirty percent of the facilities have had costs in excess of the nursing cost screens. This was due only in part to patient needs pushing costs in excess of the screens. It is highly probable that a major portion of the cost overruns were the result of a failure of homes to document their services or that the documentation requirements were excessive and unreasonable. In addition, some of the services, particularly the restorative services, were not observed with sufficient frequency in the time/motion study to make accurate estimates of the costs incurred when these services were provided. Finally, some of the classifications need to be collapsed and restructured (e.g., medications and injections may be merged into one classification).

The problems with patient assessment have undoubtedly affected the growth in nursing home rates in Ohio. As can be seen in Table 3, there was a dramatic growth in average rates when the new system was introduced. Further, the range between the lowest and highest rates particularly for SNFs and ICFs nearly doubled with the new system. The greatest growth in rates has occurred within ICF-MRs and public facilities.

Table 2
OHIO NURSING HOME RATES

	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
<u>SNF</u>				
Average Per Diem	30.40	36.81	38.56	42.19
Highest	43.00	63.74	76.04	73.23
Lowest	17.26	22.83	23.57	26.38
<u>ICF</u>				
Average Per Diem	23.16	31.61	33.62	36.79
Highest	37.89	63.74	70.59	73.23
Lowest	12.82	10.09	20.06	24.46
<u>ICF-MR</u>				
Average Per Diem	30.10	42.20	44.59	52.07
Highest	62.51	67.41	71.94	84.18
Lowest	10.67	21.90	23.02	24.29
<u>All Facilities</u>				
Average Per Diem	26.26	33.92	36.02	39.76
Highest	62.51	67.41	76.04	84.18
Lowest	10.67	10.09	20.06	24.29

Source: Ohio Department of Public Welfare.

Part of the increase in rates has been due to the patient assessment payments. However, other components of Ohio's reimbursement system have also contributed to rate increases. Rate increases have, in turn, made Medicaid recipients more attractive. While other factors may be involved, rate changes have certainly been a part of the 25 percent increase in utilization between 1979 and 1981 (that is in 1979, 49,700 clients were in nursing homes at some point during the year; in 1981, there were 62,000 clients).

4. Washington

Washington employs a combination of ADL scores, cost reports and regression analysis. Information on the dependent variable (patient care staffing) is collected from recent cost reports or certified quarterly reports provided by the contractor. The independent variable is the functional status score of the recipients as determined by the Katz ADL Scale. The difference between each facility's reported patient care staffing hours and the predicted hours is computed. The standard deviation of the difference is also calculated. A patient care staffing ceiling is then calculated, defined as the predicted hours plus one-and-three quarters (1 3/4) standard deviations. The state will then pay the actual hours incurred up to the ceiling. The state however, can also adjust allowable or "standard hours" in facilities where the characteristics of patients have changed and the staffing levels are below predicted levels.⁹

The standard hours are then multiplied by an adjusted wage rate. The wage rate for patient care personnel is 90 percent of the prevailing wages for nursing assistants, licensed practical nurses, registered nurses and non-contractual therapists and related restorative employees.

5. Maryland

Maryland has proposed new regulations which will become effective January, 1983 and which will recognize patient needs and related costs. Maryland will also use ADL classifications to set rates. Specifically, patients will be assessed in terms of their dependency in bathing, dressing, mobility, continence and feeding. Patients will then be classified as light care (dependency in 0-2 ADL classifications) moderate care (3-4) or heavy care (5). In addition, if a patient is dependent in all five ADLs and is receiving decubitus ulcer care or tube feeding or requires turning and positioning on a 24-hour basis, he is classified as "heavy special care."

These care levels are then assigned a specific daily hour requirement (e.g., daily hours required for light care are 1.44 while those for heavy special care are 2.86). The

costs assigned to those hours are determined by weighting each hour by the proportion of time expected from five categories of personnel (director of nursing, registered nurses, licensed practical nurses, nurse aides, certified medication aids) and multiplying the weighted time by an adjusted wage rate determined by the state for each personnel classification.

In addition, the state will use a similar technique to recognize and pay for decubitus ulcer care, tube feeding, turning and positioning, ostomy care, oxygen/aerosol therapy, suction/tracheotomy, IV/subcutaneous care, physical restraints and injections. The cost of nursing supplies associated with each level of care and specific procedures is also calculated and added to the home's rate.

Patient assessments will be undertaken periodically by what the state terms as "Utilization Control Agents." In the event that a patient who has been at a higher ADL classification for a minimum of two months improves, i.e., is reclassified at a lower level, the home will continue to receive the higher payment for the patient for a maximum of two months. This bonus is designed in part to overcome the incentives which may exist in this system to keep patients classified at higher levels in order to maximize reimbursement.

6. New York

The 1982 system in New York groups homes according to care level (ICF and SNF), size, geographic region and case mix/service needs (see pages 35-38). The case mix/service mix variables are used to classify homes as high, medium or low intensity. Regression analysis identified which of the relevant variables affected costs within four major groups of homes (freestanding SNFs, hospital based SNFs, freestanding ICFs and hospital based ICFs). The variables used differed according to group, with hospital based ICFs having the fewest variables (Functional Score and Mental Score from the DMS-1) and freestanding SNFs the most (nursing score from the DMS-1, percent of discharges sent to hospitals, and the ratio of ancillary costs to direct costs). The regression permitted the

state to group homes according to whether they are high, medium or low intensity and then to attribute costs associated with each level. As described below, these costs then are used to set limits within each rate classification.

7. Utah and Massachusetts

These two states use patient assessments only for high cost, heavy care patients. The definition for those patients, however, differs. In Utah if a hospitalized patient requires nursing care and if the cost of specialized care, equipment and supplies exceeds 125 percent of the SNF rate, then the state will negotiate a specific rate for a specific time period for the patient with a nursing home. In Massachusetts, if a patient is backed up in a hospital with more than 150 days of administratively necessary days, then the state will pay any nursing home which accepts the patient 120 percent of the SNF rate for the first year of residency and 110 percent of the SNF rate for the second year of residency. Thereafter, the home would receive the SNF rate for the patient.

Both systems are focused on hospitalized recipients who need only nursing home care but who may find difficulty in gaining access to a home because they require intensive nursing home care. Neither state, however, formally defines the medical, social and/or psychological needs the patient must demonstrate. That determination is made on an ad hoc basis in Utah (under the guidance of professional judgement and projected costs) and on a length-of-stay basis in Massachusetts.

The primary advantage of this approach, however, is that it assists expensive, hospitalized patients in need of nursing home care to receive that care. As an aside and based solely on anecdotal information, a number of hospitals in states with limited hospital day coverage have paid nursing homes a premium to admit these patients. In these cases providers are supplementing public policy. This highlights the need for states to develop programs which not only encourage hospitals to place patients in nursing homes as quickly as is medically advisable but also to encourage nursing homes to accept these patients.

G. Case Studies

A review of national trends in reimbursement systems fails to recognize the way in which reimbursement components interact within any given system and the decisions that states must make when designing a new reimbursement mechanism. The following briefly reviews the operation of four state programs: New York, Kentucky, Wisconsin, and Utah. It presents the pros and cons of these systems as a means for establishing some general recommendations we can make about the construction of nursing home reimbursement programs.

1. New York

In October, 1981 New York redesigned its reimbursement system for its residential health care facilities (RHCFs). This is the general term the state uses for its nursing homes, both SNFs and ICFs (the latter being referred to as health-related facilities, HRFs). The state felt that changes in recent years had weakened the payment mechanism's capacity to constrain costs and that it was necessary "to re-establish the primary principles of cost containment in the RHCF reimbursement methodology." Specifically, the Office of Health System's Management (OHSM), the agency responsible for setting rates within the State Department of Public Health, argued that:

- a. The RHCF cost base was out of date;
- b. The impact of the prospective rate had been minimized, and;
- c. Comparative cost standards had been eliminated.

Attempts to achieve those goals, however, had to be reconciled with objections raised by the industry – particularly the voluntary and public homes – that moves toward efficiency and cost containment would adversely affect homes with sicker patients. In fact, even after adjusting for case mix and service intensity it appeared that more stringent payment limits would have had a disproportionate impact on voluntary and public institutions. Rather than address whether the high costs of the non-profits was justifiable, the state adopted a system of groupings, cost ceilings and "transition factors"

which permits high cost homes to bridge the previous system to the new one with minimal disruption.

In order to develop an appropriate grouping of homes and identify important factors contributing to cost, the state identified all the major variables they felt affected costs and used regression analysis to test those relationships. A number of variables were eliminated as inappropriate. Ownership (proprietary, non-profit and public) was dismissed because it was not indicative of "the valid needs of the patients nor is it a valid prediction of justifiable reasonable cost." The volume of Medicaid was also viewed as being unrelated to needs of the patient or costs incurred by the facility. The number and percentage of private rooms was also eliminated because again it was felt that "the fact that a facility has more private rooms than another facility should not necessarily predict sicker patients."

Three groups of factors were selected: size, geographic region and case mix/service mix variables. Once these variables were selected, regression analysis was used to identify the relationship between costs and relevant variables for four groups of homes: Free-standing SNF's, Hospital-based SNF's, Free-Standing RHCFs and Hospital-based RHCFs.

The reasons for selecting these groups seems readily apparent but should be reviewed. The distinction between hospital based and free-standing rested on "fiscal and programmatic" differences.

The difference between the two types of facilities are primarily attributable to the methodology used to account for costs. A free-standing RHCF is generally an independent medical facility organization whose costs are solely attributable to its own operations. The hospital-based facility's costs are a combination of those costs incurred by the RHCF and those costs which are allocated to the RHCF from an affiliated hospital. Often the methodology by

which costs are allocated to hospital-based RHCs is outside of the control of the facility and is mandated by Medicare. In addition, a hospital based RHC's patient mix is affected to a great degree by hospital admissions and discharges to and from the affiliated hospital.⁸

It could be argued in opposition to making this distinction that it is not the state's function to uphold accounting practices of a federal program, that hospital-based nursing home beds do not receive preferential treatment in a number of states and that recent federal legislation encourages that payment to hospitals for nursing home care (e.g., administratively necessary days) be reduced to the level of free-standing facilities.

The SNF and ICF distinction is one of historical precedence. It assumes that these classifications indeed recognize different levels of care and that the costs associated with these levels are significant. As noted above, the relationship between levels of care, patient needs and costs are not readily apparent. A forthcoming study by the GAO suggests that costs associated with the SNF and ICF nursing homes are unrelated to patient needs and more likely a federal bureaucratic creation.

Once a home is assigned to a group, the average performance of homes within the group will act as the standard of efficiency. That standard is attenuated, however, in a number of ways. Only operating costs (broken down into direct and indirect patient care centers) are affected. Capital costs and real estate taxes are governed by separate regulations as are utilities, dental, lab, X-ray and physician services. Before a home's costs are calculated, its labor costs are adjusted by a "wage equalization factor" which makes adjustments for the actual costs incurred by a home and the average regional cost of labor. The average cost is then re-calculated through a process called centering. In this case, that involves calculating the average costs for all homes. Then, all those facilities with costs less than 75 percent of the mean are assigned a value equal to 75 percent of the mean and all those with costs greater than 125 percent are assigned a value

equal to 125 percent of the mean. The mean is then re-calculated. This new average cost plus a "variable corridor" serve as the limit. The variable corridor is between two percent and five percent of the average for all groups.

After making all these adjustments, the New York system allows for a "transition factor", a process deemed essential "in order to ensure the fiscal integrity of facilities and to avoid a precipitous change in current reimbursement levels". The transition factor applies only to facilities whose 1982 rates would be capped by the peer group ceilings. In those instances the state makes two additional calculations. The first is a transition rate – the December 1981 rate for the home plus three-quarters of the 1982 trend factor. The second is the 1980 rate for the home trended forward to 1982 without applying any ceilings. If the transition rate is greater than the 1982 capped rate but lower than the 1980 rate trended forward, the transition rate is used. If the transition rate is greater than the 1982 capped rate and the 1980 rate trended forward, the 1980 rate trended forward is used.

The transition factor for 1983 was slightly more stringent than the one used in 1982 indicating the state's intent to phase out the transition factor.

The New York approach has several aspects which should be carefully examined. The term transition usually implies a departure from the status quo, movement in a certain direction and a desired final state of change. While the state is attempting to limit increases in expenditures and change the direction of incentives, assumptions concerning peer groupings and transition factors may thwart those objectives. The "variable corridors" and "equalization factors" and "transition rates" not only diminish the disruptive effect the reimbursement system might have; they also may mask the direction in which the policy is moving. All of these factors plus the brevity of the life of the regulations fail to suggest a final desired state of the industry and the program. Finally, while the plan initially dismisses ownership as an appropriate factor for categorizing homes for reimbursement, it indirectly shields a large number of public and non-profit homes from the adverse affects of the rate system.

2. Kentucky

Kentucky has developed a reimbursement methodology which recognizes the cost incurred by each facility but attempts to tightly and justifiably limit the rate of growth in the rates paid. The Kentucky system is prospective. SNFs and ICFs are each on a universal rate year (i.e., the home's fiscal year may coincide with the state's rate year, but this is not required). Operating costs (total costs minus property costs) are projected for each home by trending forward the allowable costs in the base year. The trend factor is an index constructed by Data Resources, Inc. The DRI index in the most recent fiscal year was 7.2 percent. After allowable costs are trended forward, homes are grouped according to whether they are ICFs, free-standing SNFs or hospital-based SNFs. Costs are divided into four cost centers: nursing, dietary, property and all other. Nursing and dietary are capped at 125 percent of the median costs. Property and all other costs are limited to 105 percent of median costs. In calculating payment rates, a minimum occupancy rate of 90 percent is imputed; that is, if the actual occupancy rate is lower than 90 percent, costs are calculated as if 90 percent of the beds were filled. If the actual occupancy rate is greater than 90 percent, then that figure is used up to a 98 percent occupancy rate. This approach effectively penalizes homes which are insufficiently utilized and rewards those which are very successful. The problem with rewarding homes for high occupancy rates rests with whether or not there is long queue of Medicaid and private individuals able to pay the nursing home fee and waiting for placement. If there is, and work by William Scanlon suggests that this is not uncommon, then the reward for high occupancy rates may be unrelated to the quality of the home (e.g., excellent care, pleasant surroundings, etc.) but to the "excess demand" for the services.⁹

Once the costs by cost center are calculated they are summed and total costs derived. The total costs in turn are capped at 110 percent of the median for ICFs and free-standing SNFs. The hospital based SNF beds are capped at 165 percent of the maximum for free-standing SNF beds.

If a home's total costs are below the maximum and the home is not publicly owned and operated, it is eligible for a cost incentive factor. Proprietary homes can also receive an additional investment factor. Both factors are inversely related to the home's total costs; that is, the lower the costs, the higher the factor. The range for the investment factor was \$.53 to \$1.38 per diem and the incentive factor, \$.13 to \$.87. In no instance, however, can the total costs plus the incentive and investment payments exceed total maximum payment permitted.

The Kentucky approach relies upon five mechanisms for containing costs: limiting costs which are deemed allowable, limiting allowable cost increases by a trend factor which is not derived solely from behavior in the industry, limiting total cost, according to industry norms, limiting cost centers according to industry norms, and rewarding homes for incurring costs below the maximums.

The use of a median cost experience to set limits has the advantage of disregarding outliers (those with extremely high or low costs) and encouraging industry behavior which has costs tightly grouped around the limits (i.e., total costs plus incentives equal the maximum allowable costs). This in turn would justify tighter limits around the median over time, e.g., 105 percent of the median instead of 110 percent. The assumption here of course, is that the median group behavior is the desired behavior. There may be other norms or standards which are preferable; but that requires careful assessment, definition of the product desired and a determination of the price the state is willing to pay.

The final observations on the Kentucky system deal with the double use of median based limits: one for total costs, the other for cost centers. This allows the state to provide more finely tuned incentives for the home. Kentucky has clearly indicated, for example, that it is willing to reimburse homes for nursing care and dietary costs that will exceed the norm, but is unwilling to do so for all other costs. In addition, the cost center limits can reduce costs below what would have been permitted with total cost limits alone. In the absence of cost center limits, if a home's total costs are under the maximum

it would receive reimbursement for those costs. With cost center limits, allocation of resources are more tightly regulated. If property costs are excessive, a portion of those costs are disallowed and total payment reduced. A minor technical problem can exist however, if the total limit exceeds the sum of the maximum limits for all cost centers. The state would have a difficult time defending a maximum limit which is unattainable. On the other hand, if the cost center limits exceed the maximum, the state may have to justify why the sum of costs deemed allowable is unallowable.

3. Wisconsin

In 1981, the Wisconsin Legislature's Joint Committee on Finance asked the Department of Health and Social Services (DHSS) to examine the feasibility of changing the nursing home reimbursement system to one which:

- o established peer groups of homes and paid one rate for each group,
- o included additional ancillary services in the base rate,
- o shifted from a calendar year to a state fiscal year for reimbursement,
- o shifted to a two-year rather than one-year reimbursement plan.

The Department prepared a thorough analysis, designed a system which met all of the legislative requirements.¹² However, in a development characteristic of the political process, a compromise payment mechanism was adopted which met none of the original legislative goals but limited 1982 rate increases to an average of 7 percent over 1981. Since both the DHSS report and the adopted payment mechanism pose interesting solutions, we shall summarize relevant aspects of both.

Approximately 38,000 of Wisconsin's 410,000 eligible Medicaid recipients reside in nursing homes. They consumed up to 70 percent of the total 1981 Medicaid expenditures in nursing home, physician, pharmaceutical and other provider services. The state provides 70 percent of the revenues generated by the 470 nursing homes in the state. Unlike most other states, however, the majority of the homes are not proprietary. Thirty-two percent are non-profit, 20 percent are public, and 48 percent are for profit. The

average cost in 1979 was \$28.89 per day. The lowest cost was \$17.00, the highest \$89.00 per day. Proprietary homes were on average the least expensive (\$26.62), followed by non-profits (\$29.41) and, finally, public homes (\$33.73). The biggest contributor to this disparity in costs was labor costs, which represented between 60 to 70 percent of the homes' expenditures. Proprietary homes, however, spent an average \$19.23, non-profit homes \$20.42, and public homes \$29.59. The state examined two factors which are allegedly related to the cost differences between proprietary, voluntary and public homes. It was argued that a disproportionate amount of patients in public homes are the heavy care, expensive patients and that the quality of care in public and non-profit homes is higher than in proprietary homes. The state however was unable to confirm either of these propositions.

The Department of Health and Social Services considered each of the proposals set forth by the legislature and concluded the following:

- a. The selection of a biennial formula was viewed as a trade-off between stability and flexibility. A methodology which set rates in a two-year calendar rather than one year would permit the homes and the states to plan and budget more effectively, allow payment mechanism incentives to have a greater effect than those which are fine tuned each year, place nursing home expenditures in the context of the state's budgetary cycle and allow a more detailed and extensive review by the legislature if that was deemed necessary. Fixing the methodology in place for two years, on the other hand, would diminish the state's capacity to adjust the system if problems became apparent prior to the new rate period.
- b. Synchronizing the nursing home rate year (January to December) with the state's fiscal year (July to June) was strongly endorsed. The existing system created projection problems when the fiscal year for rates crossed the state fiscal year. It was an accounting convention that the state felt could be altered with federal approval, to the state's advantage.

- c. The state had been reimbursing ancillary services (e.g., drugs, occupational, speech and physical therapy) on a fee-for-service basis. The Department suggested that if the cost for these services was folded into the rate, it would act as a capitation rate and serve as a strong incentive to improve the allocation of resources and the efficiency of the provision of care to those patients needing the most care. Arguments that such a mechanism also carries with it incentives to deny admission to possible high cost patients and underprovide services to patients residing within the home was dismissed because of the ethical constraints of the providers. It was further argued that departmental monitoring of quality of care would discover the unscrupulous. In lieu of a capitation approach it was suggested that the state might reduce the rates it paid for ancillary services (thereby encouraging homes to seek economies of scale, shift costs onto non-Medicaid patients or not provide the services) or limit the number of services provided without prior authorization.
- d. The construction of peer groups was one of the Department's more innovative recommendations. Rather than employ regression analyses similar to New York's approach, the Department used a statistical technique known as cluster analysis. Regression analysis permits isolation and examination of the effects that changes in each independent variable (such as bed size, geographic location, ownership status, patient status, etc.) have on a given dependent variable (such as cost per day). Cluster analysis, on the other hand, permits classification of homes into groups in which the differences among homes within a group are minimized while differences between groups are maximized. In terms of establishing peer groupings for reimbursement, cluster analysis may be a preferable approach to regression analysis.¹¹

The Department suggested 11 groups for its 470 homes, using licensure status, facility size, geographic location and the needs of the patient (defined in terms of primary

diagnosis and level of care provided by the home) as the critical factors. However, if the mean cost within each group was used to set the rate, the average gain or loss for homes would be \$3 to \$5 per patient day, which in turn could affect 10 to 25 percent of a home's revenues. According to the Department:

Few, if any, cost savings are inherent in a peer group methodology in which reimbursement occurs at the group mean. Facilities above the group mean would receive less, those below the group mean would receive more. The two effects would roughly balance and total expenditures would remain constant. Peer groups with reimbursement set strictly at the group mean could cause substantial disruption for the industry without alleviating the fiscal pressure in Medicaid.¹²

The Department suggested that alternative approaches be considered such as one which used the group mean as a standard and applied differential rates of increases based upon whether the home was below or above the mean (higher if below, lower if above). Another approach might be to limit the application of mean costs to support costs, similar to Medicare's 223 limits.

Given all of this – the legislative mandate and the Department's analysis – the 1982 formula was very different than what might have been expected. The desire for simplicity and political acceptability resulted in trending forward each facility's 1981 average adjusted costs (based on the 1981 cost based methodology). The trend factor was variable – 4.75% to 10%. Homes with average costs below the 60th percentile of costs for each level of care (SNF and 4 levels of ICF care) received larger increases than homes whose costs exceeded the 60th percentile.

The net result of this system was an approximate 7 percent increase in rates. The state received, however, an added bonus in terms of a 3 percent reduction in utilization. Why this has occurred is not entirely clear. The recession may have prodded relatives who

were unemployed or laid off to take elderly members of their family into their homes and care for the infirm in exchange for their Social Security checks. Reductions in inflation also make it easier for the poor living on fixed incomes to survive on their own. Further, the industry may have seen the end to liberal growth in nursing home expenditures. Given strong signals put out by the state such as a moratorium on building, a legislative mandate to re-examine reimbursement policy and a state rate that increased at less than half the rate of recent years, the nursing homes may be attempting to diversify their patient mix. State officials, however, concede that these factors may have very weak effects, if any, on utilization and can not fully account for the 3 percent decline.

4. Utah

Since July 1, 1981, Utah has employed a modified flat rate system. Five of six classifications of nursing home care are assigned separate flat rates (skilled nursing care, intermediate care, mentally retarded level 1, mentally retarded level 2 and mentally retarded level 3) which are adjusted for the property rate differential and the return on equity for each home. The 1982 rates were determined by a Nursing Home Flat Rate Reimbursement Committee, a committee composed of representatives from the state legislature, the Department of Health, the Utah Health Care Association and other providers who are not members of the Association. The Utah system has several interesting features:

- a. In 1983 and each following year, the rates are to be set through "pre-legislature negotiations where rates will be developed in support of the annual Department budget. After the legislative session, there will be a second negotiation of payment rates. These negotiations will include any needed redefinition of the nursing home program in response to legislative action." Thus, the legislature will play the pre-eminent role in the process.
- b. While this approach may hark back to the negotiated rate process common to many states prior to 1976 "reasonable cost-related" requirements of the federal

government, that resemblance may be superficial. In Utah, the availability and use of supporting data is a critical part of the process. Homes will still be required to submit annual cost reports. The state will continue to audit reports. The method for determining the inflation index is described in regulation. The importance of using appropriate "economic and comparative data" to set the rate is stressed. While the legislature serves to approve, allow and redefine the rate, their decisions will have the benefit of economic and financial data; i.e., the mechanisms for supplying the data were established at the same time that the negotiation process was developed.

- c. The treatment of property costs in any flat rate system is particularly troublesome during the transition period from a cost based payment mechanism. Under the cost based system the state essentially has underwritten a large portion of facilities' property costs. The state has set the ground rules under which proprietors have entered into contracts and obligations with financial institutions. At the same time, some of those property costs were inflated solely to maximize state payments. Further attempts to regulate creative sales and leases of homes through a cost-based system have often led to very complicated accounting procedures which in turn have also distorted the nature and amount of a facility's property related financial obligations. Given all of these factors, how can a state minimize the disruptive effects of shifting to a flat rate system which does not explicitly recognize each facility's property costs.

Utah has designed a rather interesting solution to this problem. In the base year (1982) each home's property costs are divided into those which are current (i.e., included in the March 1981 per diem) and those which are historic (i.e., the cost of the beds in the year that the beds were first licensed). The state then adds 85 percent of current property costs and 15 percent of historic costs.

After the composite rate for each provider is calculated, two dollars is deducted from that rate and added to the base rate. The property per diem rate remaining is the "property rate differential." Each facility will have its own property rate differential with the exception of those facilities with composite rates of two dollars or less. Those facilities with no property rate differential will still have two dollars added to their base rate. Once determined, however, the property rate differential will not be changed, regardless of sales or changes in lease arrangements. The two dollars added to the base rate, however, will be inflated with operating costs when new rates are determined each year (in recognition that general inflation would represent a part or all of the inflation in the real estate market). Thus, the state was able to recognize cost differentials (initially) and yet construct a methodology wherein those differentials represent a smaller part of the total rate with each successive year. Equally important, the state has been able to free itself from monitoring real estate transactions. It has essentially incorporated a fee-for-capital in the rate. The use of that fee is up to the discretion of each home.

- d. Under a simple flat rate system, a home maximizes its profits by minimizing its costs. This not only creates strong incentives for efficiency but also discourages homes from admitting heavy care expensive patients. Utah has addressed this problem by creating a special rate category for intensive skilled care patients. If a hospitalized patient requires nursing care and if the cost of the specialized care, equipment and supplies required by the patient would cause total costs for the patient to exceed 125 percent of the SNF rate, then the state will negotiate a specific contract rate for a given time period with a nursing home. This provision allows the state to minimize the number of patients backed up in hospitals awaiting placement, minimize the hospital expenses incurred by those patients and make more appropriate use of health

care resources. The problems encountered by non-hospitalized heavy care patients seeking admission to a nursing home are not resolved by this provision, however. In fact, it creates a strong incentive for patients experiencing difficulty gaining admission to a home, to have their doctors hospitalize them first.

H. Recommendations

The national surveys and the reviewed case studies suggest methods by which states might improve their reimbursement systems. Specifically, states should consider the following changes:

1. Reimbursement policies are among the most powerful policy tools available to states. Payment mechanisms therefore should be consistent with state policy and goals. They should explicitly recognize: the existing and desired distribution and amount of beds; the number of recipients receiving care and those waiting for care; the rate of growth in beds, patients and costs; the amount of cost increases due to inflation, increases in intensity, changes in the SNF/ICF distribution, and utilization; expected growth in state revenues and the growth and availability of substitutes and complementary services for nursing home care.
2. If the state wishes to control its payments for capital it should adopt an approach which either freezes capital payments at existing levels, imputes a fee-for-capital or tightly limits the range of capital costs it will recognize.
3. Profits and returns on equity should be directly related to efficiency and inversely related to costs adjusted for case mix.
4. The state should re-examine the variables it uses to group homes for rate setting. Specifically, distinctions based on level of care (SNF/ICF), free-standing or hospital based beds, ownership and bed size may be unsuitable.
5. Efficiency need not be defined in terms of normative behavior. The state can also consider using low cost homes which meet state quality standards as the

basis for reimbursement. This approach was suggested by the Mooreland Committee in the mid 1970s.¹⁵

6. States should reconsider their use of the "all-item CPI" as a trend factor for settings for costs or rates. The GNP deflator, HCFA Nursing Home Price Input Index and/or a state-designed composite index may be more reflective of costs incurred by the industry and certainly more advantageous to the state.
7. States need not trend all homes forward with same inflation factor. Within peer groups (classifications which define comparability), homes with different costs might have different inflation factors applied; e.g., those homes with low per diem costs would have higher inflation factors than those with high per diem costs. If a state adopts this approach it should also consider making adjustments which recognize the case mix and patient needs within each home. Without that adjustment, homes which accept heavy care patients may be penalized twice, i.e., the rates may fail to cover costs incurred and the rate of increase for future revenue will be reduced.
8. States can control total costs and the distribution of costs between cost centers by the use of multiple cost screens. Total costs should be capped. In addition if the state is concerned that direct patient care might be shortchanged in order to meet other costs (for example, capital costs), cost centers should be capped as well.
9. Frequently when states want to assure that homes spend a minimum on certain types of expenditures (e.g., food or nursing care), they increase the cost screens applicable to those cost centers. If minimum cost expenditures are the concern, cost minimums should be set instead of, or as well as, maximums.
10. Placement and admission of heavy care, expensive patients is a problem in many states. Reimbursement systems which recognize the special costs of only these patients (such as Utah and Massachusetts) may improve the patients',

providers' and state's situations. The bonus for heavy care patients could also be expanded to include those patients who are bed-ridden in their own homes and need nursing home care. A more global approach to case mix/service need payment adjustments may improve the allocation of patients and costs throughout the entire industry.

11. Reimbursement systems which serve as a "transition" to a new system should be designed to reach a specific goal within a specific time. If the transition acts solely as a means to mute change and protect vested positions within the industry, then the status quo will be preserved under the guise of change.

IV. HOSPITAL REIMBURSEMENT

This chapter is devoted to hospital reimbursement by Medicaid. Sections A and B consist of a summary of the results of the survey on the technical aspects of how states reimburse hospitals under the Medicaid program. Since several states have been quite innovative in making use of the flexibility provided by the 1981 Omnibus Reconciliation Act, Section C is devoted to several case studies describing a representative sample of these innovative programs. Section D completes the discussion by listing the cost containment activities which were opened up to states by the passage of the 1981 Omnibus Reconciliation Act and the 1982 Tax Equity and Fiscal Responsibility Act, and also includes a discussion of some of the cost containment possibilities that were available to states prior to the passage of these acts.*

A. National Trends

Fifty states responded to the 1982 NGA survey on hospital reimbursement. Thirty-three states reimburse according to Medicare principles and seventeen according to alternative reimbursement systems. Of those employing alternatives, fourteen use prospective methods and three retrospective. The upper payment limits in nine of the states is set by Medicare's reasonable cost reimbursement. Three states use statewide or peer group norms to set limits. Two states use negotiated caps and the remaining states employ a variety of other techniques. Not surprisingly, the most common units of payment are per diem rates (eleven states) and reimbursement per admission (five states). Unlike nursing home inflation indices, most states have constructed their own composite indices for inflation (twelve states). Not one state in the 1982 survey relied solely or principally on the CPI. Most of the adjustments made to the amount reimbursed were related to how a hospital made use of its existing capacity. Nine states made

*It should be noted that this report was prepared prior to passage of legislation changing Medicare hospital reimbursement to a methodology based on diagnosis-related groups (DRGs). It does not therefore include an analysis of the provisions of this legislation. However, A general discussion of the flexibility provided in the 1981 Omnibus Reconciliation Act, and the modifications made in the Tax Equity and Fiscal Responsibility Act of 1982 is presented in Appendix A.

adjustments for changes in projected volume and five for changes in occupancy limitations. Variations for case mix accounted for the next most frequent adjustments. Three states had an intensity adjustment and two states had two case mix adjustments. Most of the exceptions, on the other hand, were primarily concerned with factors beyond the control of the hospitals (six states recognized exceptions for "uncontrolled circumstances") or beyond the calculations of the rate setting process (seven states recognized exceptions for new programs and services and six states recognized that new hospitals may appeal on the basis of a lack of previous cost experience). Six states also permitted hospitals with unusual or unexpected case mix experience to appeal rates.

B. High Volume Medicaid Hospitals

A more recent phenomenon encouraged by the 1981 Omnibus Budget Reconciliation Act and reported in the July 1982 NGA survey has been the preferential treatment of high volume indigent hospitals. Of the forty-three states responding to the survey, twenty employed alternative hospital reimbursement methodologies and eleven made special exceptions for hospitals whose patient census and/or revenues reflected a disproportionate dependency on or service to Medicaid clients or non-Medicaid indigent patients.

The high volume Medicaid hospitals play a very important role in the Medicaid program. They tend to be public and/or teaching hospitals with open admissions policies. They also tend to care for a large proportion of the Medicaid population. For example, in 1980 more than 200 hospitals participated in Tennessee's Medicaid program, yet five hospitals accounted for one-third of the patient days, ten for nearly one-half, and 20 hospitals accounted for 70 percent of the patient days.

When states reduce hospital coverage and/or reimbursement, high volume Medicaid (HVM) hospitals are immediately affected. First, they realize an immediate reduction in revenues for their existing patients. In addition some other hospitals will deny Medicaid admissions or limit admissions to simple, inexpensive cases. These patients are often sent to or admit themselves to HVM hospitals. This increases the admissions of Medicaid

clients to HVM hospitals as well as increasing the expense and complexity of the cases admitted. Finally, other hospitals may engage in the practice of patient dumping, defined here as the discharge of a sick Medicaid patient from one hospital to a HVM hospital solely on the grounds that the client has exhausted his Medicaid coverage (reimbursable hospital days). These dumped patients represent the most seriously ill portion of the hospitalized patients and can result in an enormous drain on HVM hospitals. For example, a 1978 study of 58 hospitals throughout the nation examined the effects that the sickest patients had on the hospitalss costs. 6.6 percent of the patients admitted incurred bills in excess of \$4,000 yet they accounted for 34.5 percent of total charges and spent an average 27.2 days in the hospital. In a related example, less than 10 percent of the Medicaid patients hospitalized in Michigan (approximately 1 to 2 percent of the total Medicaid eligible population) represented 50 percent of the Medicaid hospital expenditures.¹⁴ The issue here, of course, is that state policies which cause a pronounced shift of catastrophically ill patients into HVM hospitals may have a catastrophic effect on these hospitals.

In order to partially offset these losses, states which make special exception for HVM hospitals have done so by either eliminating any cap on hospital costs for these hospitals (e.g., as proposed in Louisiana), providing for a less stringent cap on HVM hospitals (e.g., Pennsylvania, Illinois or Alabama) or granting special relief through a fund which helps hospitals overcome cash flow difficulties (e.g., Illinois). The type of preferential treatment may be uniform (as in Pennsylvania) or tiered according to how dependent the HVM hospital is on Medicaid or other public programs (as in Illinois).

It should be noted, however, that even when states have made special exceptions for HVM hospitals, the magnitude of difference between the reimbursement practices for HVM and non-HVM institutions has generally not been dramatic. In fact, the application of differential HVM policies in states and the implications of how these policies might affect both HVM hospitals and the Medicaid program has not been fully explored. If HVM

status meant a significant increase in reimbursements, the state might make HVM status dependent upon meeting several conditions.

1. The state might set minimum management standards as a pre-condition. The hospitals would have to meet those standards or accept assistance (funded by the state) to help them meet the standards. Those standards, however, should not interfere with the mission of the hospitals.
2. The state could impose special utilization controls and monitoring efforts. If these controls resulted in a large reduction in utilization the state should also consider additional financial assistance for the hospitals to adjust to the lower volume of patients.
3. The state might also require that hospitals participate in experiments which would explore ways of improving efficiency within the hospital, efficiency within the delivery system or the financing of health care. The range of options extend from special programs to affect physician behavior within a ward to a county-run primary care network.

The net result of these efforts would be that states could treat HVM hospitals as preferred providers that are particularly important to the state while simultaneously helping essential institutions to survive. Some or all of these conditions, however, might require a federal waiver.

C. Case Studies

In this section we shall examine three of the systems recently adopted. It should be noted that reimbursement methodologies tend to have two common characteristics: they are simpler than those systems adopted prior to 1980, and they usually allow for preferential treatment of HVM hospitals.

The changes in the federal law set forth in the 1981 Omnibus Budget Reconciliation Act and the 1982 Tax Equity and Fiscal Responsibility Act have given states broader leeway and greater ease in the development and implementation of new hospital

reimbursement systems than have existed previously in the program (see Appendix A). It should also be stressed that that is a relative statement. The development of a new methodology is still difficult and requires careful attention not only to the technical and economic impact it will have on hospitals and to the effect it will have on patient access to hospitals, but also to the political reception that it will receive in the Governor's office and the legislature.

The purpose of the following descriptions is to show what types of activities are permitted and feasible, where possible to give some idea of the time required to develop and implement the program, and to indicate the order of magnitude of the savings that might be expected. In choosing the states for inclusion in this section, the main focus was on including examples which were typical of the approach being illustrated and which were most useful to other states in terms of their replicability.

The first case study is an example of a prospective hospital payment system covering only the Medicaid program. The program implemented in Kentucky in 1982 is used as the example of this kind of activity. Prudent buying of hospital services is now allowed under the Freedom of Choice waivers that are available. No programs making use of this flexibility are yet in operation, but since this is probably one of the most promising cost containment opportunities presently open to state Medicaid programs, we will provide a description of the program that California is planning to implement shortly. The necessary waivers to carry out the program have been granted by the Health Care Financing Administration. Michigan has had – until very recently – a system with a sophisticated set of limits on payments and an incentive component, and this is the subject of the third case study. The final case study is of the relatively simple prospective payment system used by North Carolina.

1. Kentucky

The inpatient prospective payment program implemented by the Kentucky Medical Assistance program on March 1, 1982 is a good example of the sort of prospective

payment program that can be developed reasonably quickly and implemented unilaterally by a Medicaid program. It uses techniques and information that are readily available and has good prospects of resulting in substantial cost savings, even in its first year of operation.

Under this system the unit of payment for hospital inpatient services is a per diem which includes both routine and ancillary service costs. The rate is established for a calendar year (independent of the hospital's fiscal year). The first rate year for Kentucky was calendar year 1982. The steps used in calculating the prospective per diem are as follows:

- a. Establish the base year for the calculation. For Kentucky, this is the fiscal year of the hospital which ends in the period July 1, 1980 through June 30, 1981.
- b. Remove any costs that are not allowable under the program and compute the Medicaid share of the total inpatient costs of the hospital.
- c. Trend these costs forward to the start of the rate year using an index that is developed from the historical increase in Medicaid costs in the state, then project the results forward into the rate year using an inflation projection developed by Data Resources, Inc.
- d. A return on equity is added for proprietary hospitals.
- e. The result of the above calculations is divided by the number of Medicaid days provided by the hospital in the base year.
- f. The per diem limit for the hospital is computed. For this purpose the hospitals are sorted into peer groups by bed size (0-50 beds, 51-100, 101-200, 201+), and the two university teaching hospitals are removed from the peer group in which they fall. The upper limit on per diem cost is 110% of the weighted average per diem for the peer group. For the university teaching hospitals the upper limit is 150% of the median, and for hospitals which serve a disproportionate number of

Medicaid patients (more than 20% of admissions being Medicaid) the upper limit is 120% of the median.

- g. The allowable per diem operating cost is the lesser of the limit calculated in f. and in e. above.
- h. Minimum imputed occupancy levels are incorporated into the Medicaid per diem capital cost of the hospital. The hospital receives less than its actual Medicaid per diem capital cost if its occupancy is less than: (1) 60% for hospitals with 100 or fewer beds, or (2) 75% for hospitals with 101 or more beds.

Retroactive adjustments to the prospective per diem will be made for audit adjustments, calculation errors, or misprojections of inflation by Data Resources, Inc.

A rate appeal process has been established to deal with additional costs resulting from the introduction of services needing Certificate of Need approval, major changes in case mix, extraordinary circumstances, etc.

2. California

California is the first state to take advantage of the provisions of the 1981 Omnibus Budget Reconciliation Act which make it possible for a state to obtain waivers to prudently purchase services, and to restrict Medicaid clients to hospitals which provide services efficiently and effectively. The application for the necessary waivers was submitted to the Department of Health and Human Services in July by the Governor of California, thereby making it eligible for "fast-track" consideration. The Secretary of DHHS has approved the necessary waivers, so the project can now proceed. At the time of this writing the project has not yet started, but the proposal submitted to DHHS contains a fairly complete description of its plan of operation, and was used as the basis of the description that follows.

The program sets up a framework for contracting with selected hospitals to provide inpatient services to Medicaid clients. Within the general framework, great flexibility is provided. Initially the contracting will be done by a negotiator appointed by the

Governor, but on July 1, 1983 this function will be taken over by a Commission, with the negotiator as its Executive Director.

Within geographic areas the negotiator will select the hospitals with which Medicaid will contract. The process of selecting the hospitals may be competitive bidding, negotiation, or some other method deemed appropriate by the negotiator. This process will begin in urban areas and will then be expanded to cover rural areas as well.

Until the contracting process is initiated in an area the hospitals in that area will continue to receive reimbursement for services provided to Medicaid clients under the standard cost based reimbursement system. Certain types of hospitals will not be subject to the contracting provisions; namely, state hospitals, health maintenance organization inpatient hospital services, and regional and specialty hospitals. The negotiator is required to ensure that Medicaid clients have adequate access to care, both in terms of travel time and the number of hospital beds available for their use. All hospitals will be paid for emergency services.

The method of arriving at contracts is left very much to the discretion of the negotiator. The proposal states that it will be by "bidding, negotiation, and/or other methods of procurement." The form of payment is left equally open – it may be on a "capitation or prepayment basis, or through use of other methods that the negotiator determines to be feasible".

This is one of the most exciting competition demonstrations now taking place, and has the potential for substantial savings to Medi-Cal.

3. Michigan

The State of Michigan has for some time had a prospective limit and payment system for inpatient hospital services rendered to Medicaid clients. The incentive portion of the system was applied first to the hospitals with a heavy load of Medicaid patients, and will be expanded to cover all hospitals over the course of the next few years. On July 1, 1982 the State's Department of Social Services submitted a state plan amendment

which imposed a further limit on the payments that the Medicaid program would make. This new limit is on the hospitals' per diem costs, and is based on the 75th percentile of costs of hospitals in a peer group. The previous limits had were on the hospital's own historical cost, adjusted for inflation and other factors. It is estimated that the new limit will save \$16 million, or 3.5% of the state's inpatient hospital Medicaid expenditures. The following is a brief description of the way in which the payments are calculated. Any state interested in applying the same types of limits would be advised to obtain a detailed description of how the program operates.

Outline of the payment system:

The amount to be paid to the hospital for inpatient hospital services is the least of:

- a. Customary charges,
or the Medicaid share of:
- b. Allowable cost as defined under Medicare regulations,
- c. The individual hospital limitation on expenditures,
- d. The individual hospital limitation on operating costs.

The individual hospital limitation on expenditures is calculated by taking the hospital's allowable costs in a base year, removing capital costs and certain other audit, legal and insurance costs, and then trending the result forward to the payment year to account for inflation. The capital and other pass-through costs are then added back at the level actually incurred in the payment year to arrive at the individual hospital limitation on expenditures. For hospitals which are under the incentive payment system, an incentive payment is given to the hospital if the actual allowable costs are less than the individual hospital limitation on expenditures.

The individual hospital limitation on operating costs (IHLOC) is the sum of: 1.) capital and other pass-through costs, 2.) education costs, and 3.) number of inpatient days times the operating cost limit for the peer group in which the hospital falls. The peer groups are defined in terms of bed size and rural or metropolitan location, and

adjustments are made for area wage levels, different fiscal years, and case mix. The limit is the adjusted cost per day of the first hospital at or above the 75th percentile. Retrospective adjustments are made for changes in the inflation index and changes in case mix. An upward adjustment is made to the IHLOC for hospitals with more than 25% of their inpatient days attributable to Medicaid.

There is an option whereby the hospital may elect, or be required, to undergo a budget review instead of having its rates established by the formula just described. There is also an appeal procedure, but certain aspects of the system are defined as non-appealable. The state is considering modifications that would mitigate the disproportionate impact of the program on certain hospitals.

4. North Carolina

The prospective payment system in use in North Carolina is a good model in that it is simple, provides incentives to the hospitals to become more efficient, and encourages the use of lower cost hospitals. The system starts with the hospital's costs in a base year and breaks them into two components: capital costs and operating costs. The hospital's per diem capital cost and its per diem operating cost are computed. The capital component of the prospective per diem rate is the higher of the capital cost per diem in the base year and the most recent capital cost per diem established upon appeal. The operating cost component of the prospective per diem is obtained by adjusting the base year operating cost per diem for the impact of inflation, the measure of inflation being based on the National Hospital Market Basket Index. The prospective rate is the sum of the capital and operating cost per diems thus calculated. Hospitals with rates below the mean for all hospitals are paid the prospective per diem for all acute care days without any limits. Hospitals with rates above the mean are paid the prospective rate for days up to 85% of the days of care provided in the previous year, and are paid a lower rate thereafter. Days of care provided by the hospital when acute care was not needed but skilled or intermediate nursing care was required are paid for at the appropriate average nursing home rate.

D. Cost Containment Possibilities.

The cost containment possibilities to be discussed in this section can be broken down into five major categories:

1. A prospective rate setting program for hospitals,
2. Medicaid payment systems with incentives to control utilization,
3. Limit on payments or days of care,
4. Prudent buying of services, and
5. Programs to reduce utilization of services.

Within each of these major categories there are numerous options. In the remainder of this section we will list some of these options, discuss the possibilities for their success, and estimate the amount of time that would be needed in order to implement a program. We will also indicate which programs were made possible by legislative changes in 1981 or 1982.

1. Establishment of a prospective rate setting program.

Several states have already set up state hospital rate setting programs in an attempt to control the rate of increase in hospital costs. Much has been written elsewhere about such programs so we will not repeat it here. It generally takes two or three years for a rate setting agency to become established and to have an impact on hospital cost increases. Rate setting agencies, in their first year of setting rates for Medicaid, often produce increased Medicaid payments, although this can be avoided by judicious wording of the enabling legislation. Numerous studies have assessed the impact on hospital costs of mandatory state rate setting programs. The conclusion of these studies is that a rate setting agency is likely to reduce the rate of inflation in hospital costs by about 3% per year, but the amount of the reduction in the rate of inflation varies greatly from year to year and from state to state.

Establishing a rate setting agency to cover a number of the payors for hospital services can be a time-consuming process and does not coincide with current political

feelings in regard to regulation. It will generally be faster and easier, both technically and politically, to develop a prospective rate setting system for Medicaid alone. However, because Medicaid payments comprise a relatively small proportion of most hospitals' revenues, the hospitals are less likely to respond forcefully to the incentives in such a system than to a system which includes other major payors for hospital services as well. A number of states have been successful in setting up such programs. The case study on the Kentucky system describes one such program. It cannot be emphasized too strongly that, in developing such a system, care must be taken not to introduce inadvertently an incentive that encourages overutilization of services.

Before going ahead with the development of a prospective payment system exclusively for Medicaid it would be worthwhile to consider the newly enacted Medicare payment system that phases in the diagnosis-related groups payment system and whether that would meet the needs of the state. Adoption of that system could substantially reduce developmental effort, and much of the ongoing work would be done by the Medicare program. This would require, however, the development of a relevant Medicaid data base, especially for high volume Medicaid diagnoses not relevant to the Medicare population, such as uncomplicated deliveries. A description of the system is provided in Appendix A.

To summarize, state rate setting can be effective at reducing hospital costs and thus Medicaid payments in the long run, but setting up such an organization is not an effective way to achieve an immediate reduction in Medicaid expenditures. The 1981 and 1982 legislation did not change this option in any appreciable way, apart from expediting the process of applying for waivers of Medicare and Medicaid payment principles.

The 1981 OBRA did, however, give much more flexibility in the way in which payment rates for Medicaid can be established. A prospective payment system for the Medicaid portion of hospital payments could be developed more rapidly than a more comprehensive prospective rate setting system and could be designed to provide immediate savings.

2. Systems with incentives to control utilization.

Under this heading are considered various incentive payment systems which provide the hospitals or other health care providers with financial incentives to control the utilization of services. In contrast to the more global rate setting programs discussed in the previous sub-section, the systems to be discussed here would apply to Medicaid alone, although there is no reason why they could not be extended to cover other payors if desired. Two main options are available: 1) per case payment systems, and 2) capitation payment systems.

Per case payment systems:

Per case payment systems, similar to the new Medicare Diagnosis Related Groups System, have been used in Georgia and New Jersey. The basic idea of these systems is that the hospitals are paid a certain amount per case, with the amount varying according to the diagnosis of the patient and other characteristics such as age, whether there was a complicating diagnosis, and whether surgery was performed. Since the payment is independent of the amount of services actually provided to the patient, the hospital has a powerful financial incentive to control the utilization of services. The development of a system of the type that was used in Georgia or New Jersey is quite a complicated process and would be likely to take more than a year, and perhaps much longer if the necessary data were not already available in the Medicaid (or some other) data base. However, the Department of Health and Human Services intends to fund project to pursue necessary data systems for states interested in this approach. Because Medicare cost reports will be altered to be consistent with the Medicare DRG system, it may be advantageous for states to consider this approach.

Capitation payment systems:

The most common capitation systems are Health Maintenance Organizations (HMO). Medicaid programs in most states have contracts with HMOs to cover that portion of the Medicaid population who wishes to enroll in an HMO. However, to date, the penetration

of HMOs into the Medicaid population has not been great. Under the Omnibus Budget Reconciliation Act of 1981 the stringent criteria for HMOs to qualify for provision of prepaid services to Medicaid clients were relaxed, and the Secretary of DHHS was given the authority to waive some other requirements of the Medicaid program in order to make possible demonstrations of capitation payment systems. However, the Tax Equity and Fiscal Responsibility Act of 1982 rescinded the Secretary's authority to waive the restrictions on the types of organizations with whom risk sharing contracts could be made. The law appears to leave open the following options for risk sharing arrangements:

- a. Contract with federally qualified HMOs.
- b. Contract with hospitals to provide inpatient services.
- c. Contract for selections of primary care and other non-hospital services.

Under a capitation payment system a provider is paid an amount of money for accepting responsibility for the care of a specific population of Medicaid clients. The provider is then responsible for providing, or brokering and paying for, all the care requirements of the enrolled population within the range of services required to be covered. This type of payment system has all the incentives of the per case payment systems just discussed, but with the additional incentive to control overall utilization of services. In this respect it embodies all the incentives that one could wish for in regard to the cost effective provision of medical care. A number of regions are in the process of developing capitation payment systems for the Medicaid population, Boston, Massachusetts and Monroe County, New York being two notable examples.

3. Limits on payments or days of care.

Limits on payments have the advantages that they are easy to understand, easy to develop, and can be implemented rapidly. They are a valuable way in which to save Medicaid money quickly. The states have always had considerable flexibility in the amount they pay for outpatient and physician services, but until 1981 were constrained to pay for inpatient services on the basis of so-called "reasonable costs," as defined by

Medicare regulations. In the 1981 Omnibus Budget Reconciliation Act this restriction was lifted. Some of the implications of this increased freedom will be discussed in the next subsection on the prudent buying of services.

If limits are placed on either the amounts to be paid for particular services, or the number of services of a particular type that Medicaid will pay for, thought needs to be given to the incentives that are being introduced into the payment system. If these incentives are not taken into account, the short term savings resulting from the limits can rapidly turn into long term costs. For example, placing limits on the amount that Medicaid will pay for a physician visit which are substantially below the market price could have undesired results. Many physicians may refuse to treat Medicaid patients, and those who will treat them may suggest that the patient return for more follow-up visits than might otherwise have been suggested in order to make up for the shortfall in the payment per visit. Thus, this cost saving practice can result in the encouragement of Medicaid mills, and an increase in Medicaid's total expenditures.

Another type of limit that has been tried in a number of states, with varying results, is a limit on length of stay. States have imposed limits from 12 to 40 days on the length of stay for which they will pay. Often these limits are absolute, but sometimes exceptions are made for particular types of cases, or if special approval is received. Again, this type of limit is easy to impose quickly if Medicaid has an immediate budget problem. However, the results of imposing limits of this type have been varied. In Maryland, for example, a 20-day limit caused a dramatic reduction in Medicaid expenditures. This is probably due to the hospitals' determination that Medicaid patients were less desirable because of the associated risk of financial loss and their resultant efforts to screen Medicaid admissions more effectively and to monitor their length of stay more closely once they were in the hospital. On the other hand, in Tennessee a 14-day per year limit was imposed, and the average length of stay of Medicaid patients actually increased. It is difficult to predict in advance what the response of the hospitals will be to the

imposition of limits on the number of days of care covered by Medicaid. As of the Spring of 1982, eleven states had imposed limits on the number of hospital days covered.

Limits on payment per case do not provide as much opportunity for gaming as the two types of limits just discussed, but they are more difficult both to develop and to implement.

One of the possible limits to impose would be the interim limits on cost increases under the federal Medicare program that cover a declining portion of costs during the phase-in of the Medicare DRG system. Since these limits have not yet been promulgated by the Medicare program, states may have inadequate time to modify and implement them.

In summary, limits may be a convenient way to deal with an immediate budget problem, but they are not a long term solution to containing Medicaid costs. Limits on days have long been an option, but the 1981 OBRA allowed more flexibility in regard to the imposition of limits on costs. The case study on Michigan describes a system with an interesting combination of limits.

4. Prudent buying of services

Prudent buying of services is probably one of the most fertile opportunities for Medicaid cost containment which was opened up by the Omnibus Budget Reconciliation Act of 1981. Two aspects of the Act permit the prudent buying of services: 1) The provision that Medicaid need no longer pay for inpatient hospital services on the basis of "reasonable cost", and 2) the provision that Medicaid can restrict the choices of providers available to Medicaid recipients. First it will be useful to explain what is meant by prudent buying in this context. Prudent buying means one of two things: 1) Purchasing services only from providers who can provide those services at a reasonable cost, or 2) purchasing services from any provider able to supply those services, but not paying more than the cost that an efficient provider would incur for the provision of the services. There are, of course, numerous possible variations within these two main themes.

Having decided to adopt a prudent buying approach, the next question is what is the level at which the state should buy prudently? It could be units of service, i.e., laboratory tests, days of inpatient care, outpatient visits, etc; it could be for the care of cases, i.e., admissions to hospital, or episodes of outpatient care; or it could be combined with a capitation payment system to provide the maximum financial incentives to the providers.

The time required to develop a prudent buying approach would depend very much on the level of aggregation of the prudent buying.

An approach for the prudent purchase of units of service could be developed and implemented fairly rapidly, perhaps within a few months, but one which involved a capitation payment would be likely to take somewhat longer. At this writing only California has applied to take advantage of prudent buying of services. A case study on the waiver proposal submitted by the State of California is included in Section C.

Prudent buying of hospital services will be more feasible in urban locations than in rural locations. In fact, it would be impractical in a region with isolated and dispersed hospitals.

5. Programs to reduce utilization of services

Under this heading will be discussed methods for reducing utilization of services which are more administrative in nature than the methods earlier described, or which focus on directing incentives somewhere other than toward the health care provider.

Increased consumer awareness of costs

The most direct way of making consumers more aware of the cost of the services they are using is to make them pay for some portion of those services through copayments. States have had the option of charging copayments on the optional Medicaid services for some time and many states have done this, particularly for drugs. However, they have been prohibited from charging copayments or deductibles on the mandatory services, which is where most of the costs are incurred and where consumer awareness of costs is most critical. Unfortunately, the 1981 Omnibus Budget Reconciliation Act did

not provide additional flexibility in this area. Several states requested waivers from DHHS in order to implement broader copayment requirements than had previously been permitted. These waiver requests were rejected by the Health Care Financing Administration.

The Tax Equity and Fiscal Responsibility Act of 1982 permits nominal copayments for non-inpatient services for many Medicaid beneficiaries, and also permits waivers for more than nominal copayments for non-emergency use of emergency rooms. These openings give states an opportunity to reduce inappropriate use of outpatient services by imposing copayments.

An opportunity is provided by the 1981 OBRA provision that the Secretary of DHHS can grant waivers allowing states to share with clients the savings resulting from cost-effective health care delivery systems through the provision of additional services. This may have some long term impact, but is not likely to have a substantial effect on costs in the short term.

Discouraging outpatient treatment in a hospital setting

Outpatient treatment in a hospital setting is generally more expensive than the same services provided in a physician's office, and it is likely that more tests are provided in the hospital setting, further increasing the cost differential. There is also some evidence that use of inpatient services would be reduced if more of the primary care of Medicaid clients was provided in a non-hospital setting. Thus a state could save money by discouraging use of the outpatient departments of hospitals for the delivery of primary care to Medicaid clients. One way of accomplishing this goal would be to pay the same amount for the services wherever they are provided. Another, is discussed below, is arranging for the management of the care of Medicaid clients through a case management system.

Utilization review

Utilization review is included in this list for the purpose of completeness, but will not be discussed at any length because it is an option that has been available for a long time. In addition, it does not conform with the principle underlying much of this discussion, that financial incentives are a more effective method of encouraging efficient provision of services thanb complex administrative mechanisms. Utilization review can be somewhat effective at reducing utilization; but it is expensive and complex to administer, and a longer period of time is necessary for establishing it and for it to become effective. As of the spring of 1982, thirty-two states had plans for monitoring PSRO utilization review activities.

Case management

Under a case management system a primary care provider is paid a fee to manage the care of an enrolled population of Medicaid clients. Clients enrolled in such a system must go to the designated provider for all non-emergency primary care services. Such a system was first allowed under the 1981 OBRA, and provides considerable scope for reductions in cost, particularly if the case management is tied in with a risk sharing arrangement for the cost of care. Such a system will take considerable time to establish; therefore, while it is a good, long term prospect, it should not be looked to for immediate savings.

Other possibilities

The 1981 OBRA contained a number of other provisions which give states an opportunity for cost reductions. Examples are: 1) states may act as brokers to assist clients in choosing between competing health plans, 2) states may limit or suspend providers who provide more services than medically necessary or poor quality services, and 3) states may place restrictions on clients who overutilize services.

States should also consider seriously whether they should treat hospitals with a heavy load of Medicaid patients differently from other hospitals. Often the hospitals with a high volume of Medicaid patients are public hospitals in which the state or the locality pays for any deficit incurred by the hospital. In such a situation it may be counter-productive to impose penalties on the hospital because the losses incurred as a result of the penalty will go directly to the deficit, which will be 100% local funds. However, if Medicaid were to pay the full costs then the federal government would be contributing as well.

There are additional limitations on coverage which were options prior to the 1981 OBRA, and which several states have adopted. Examples which are relevant to this discussion are as follows:

- 1) Limit preoperative length of stay to one day.
- 2) Pay for specified services only if they are provided on an outpatient basis, or pay only at the outpatient rate.
- 3) Require prior authorization for specified services.
- 4) Institute a second surgical opinion program.
- 5) Deny reimbursement for non-emergency weekend admissions.
- 6) Deny reimbursement for percentage contracts for laboratory and radiology.
- 7) Impute an occupancy rate for underutilized hospitals.
- 8) Limit reimbursement hospitals for laboratory services to the high volume automated rate.
- 9) Limit reimbursement for hospital days which are not medically necessary to the rate for the least expensive setting required.

Details of which states have made use of these ideas, and how they have implemented them can be found in the publication "MEDICAID PROGRAM CHANGES: State by State Profiles," published in May 1982 by the State Medicaid Information Center of the National Governors' Association.

Summary of Hospital Cost Containment Possibilities

1. Prospective rate setting agency: Long term savings.
2. Incentive payment system for Medicaid: Short term and long term savings.
3. Limits on payments: Immediate savings, sometimes long term savings.
4. Prudent buying of services: Short term and long term savings.
5. Programs to reduce utilization of services:

Consumer awareness of costs –

Copayments: short and long term savings

Additional Services: long term savings

Discourage outpatient treatment in hospital setting – short and long term savings

Utilization review – Medium to long term savings (takes time to establish)

Case management – Medium to long term savings

Limit preoperative length of stay – Immediate savings

Pay for selected services only on an outpatient basis – Immediate savings.

SUMMARY OF MEDICAID HOSPITAL PAYMENT SYSTEM CHARACTERISTICS

	Medicare Reimbursement Principles	Are Changes Planned?	Special Treatment of Hospitals with High MA Volume	Specific Regulations Regarding Hospital Based Physicians
Alabama	No	Yes	Yes	Yes
Alaska	Yes			
Arizona	No			
Arkansas	Yes	No	No	No
California	No			
Colorado	No	No	No	No
Connecticut	Yes	No	No	No
Delaware	Yes	No	No	No
D.C.	Yes	No	No	No
Florida	Yes	No	No	No
Georgia	No	Yes	No	No
Hawaii	Yes	No	No	No
Idaho	No	No	No	No
Illinois	No		Yes	No
Indiana	Yes	No	No	No
Iowa	Yes	No	No	No
Kansas	Yes			
Kentucky	No	No	Yes	No
Louisiana	Yes			
Maine	Yes		No	Yes
Maryland	No		No	No
Massachusetts	No	Yes	Yes	No
Michigan	No	Yes	Yes	
Minnesota	Yes	Yes	No	No
Mississippi	No	No	Yes	No
Missouri	No	Yes	Yes	No
Montana	Yes			
Nebraska	Yes	Yes	No	Yes
Nevada	Yes ¹	No	No	No
New Hampshire	Yes ¹	Yes	No	No
New Jersey	No	No	No	
New Mexico	Yes	No	No	No
New York	No	Yes	No	
North Carolina	No	No	Yes	No
North Dakota	Yes	No	No	No
Ohio	Yes	No	No	Yes
Oklahoma	Yes			
Oregon	Yes	No	No	No
Pennsylvania	Yes	Yes	No	No
Rhode Island	No	No	No	No
South Carolina	Yes	No	No	No
South Dakota	Yes	No	No	No
Tennessee	Yes	No	No	No
Texas	Yes ²	No	No	Yes
Utah	Yes ²	No	No	No
Vermont	Yes	No	No	No
Virginia	Yes	Yes	Yes	No
Washington	No	No	Yes	No
West Virginia	Yes			
Wisconsin	No	Yes	Yes	No
Wyoming	Yes	No	No	No

¹With some modification

²Inpatient system is Medicare, outpatient is 78% of charges

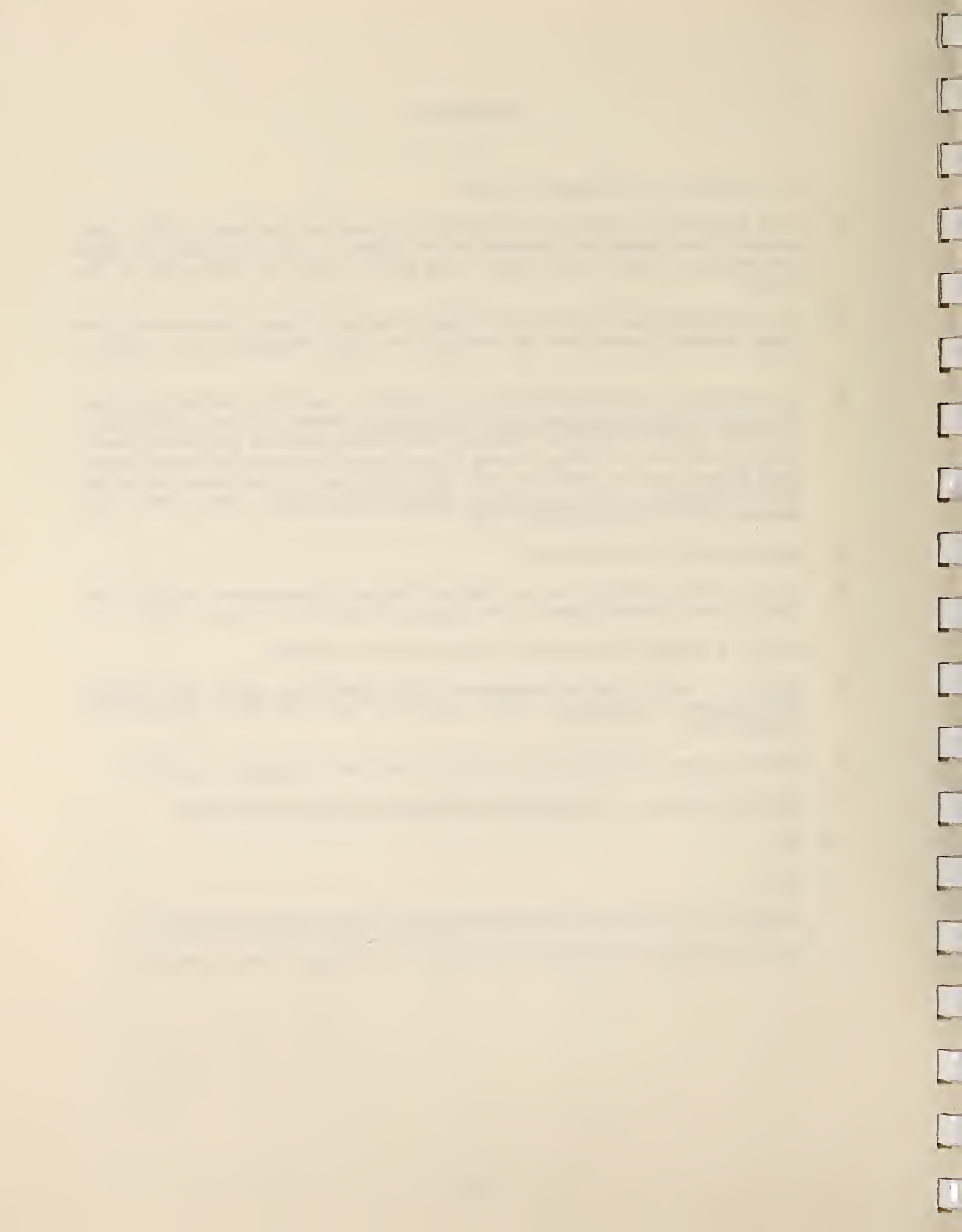
V. CONCLUSION

Hospitals and nursing homes are frequently treated as distinct and dissimilar industries. While their differences may be important, there are several developing trends which appear to be affecting both hospitals and nursing homes in a similar fashion.

1. The convergence of federal reimbursement regulations governing both types of institutions has freed states--to some extent--to apply what they have learned in hospitals to nursing homes, and vice versa. States are building upon the experiences which have been accumulated with hospitals and nursing homes in the construction of inflation indices, the treatment of capital expenditures, the adjustments for case mix severity and the development of other reimbursement policies.
2. There is an increasing tendency among states to move away from cost base systems to ones based on price with a case mix adjustment.
3. There is a growing unwillingness by states to pay for excess capacity in hospitals and nursing homes. This reluctance has assumed a variety of forms, from imputed minimum occupancy levels to a refusal to pay for new capital construction. If this lead is picked up by private, third-party intermediaries, we should expect a pronounced reduction in the growth of the supply of institutional beds.
4. States are simultaneously developing new reimbursement techniques and new health care delivery systems. Both trends are designed to temper rates of increase in institutional costs. Both sets of activities are occurring at a more rapid rate than has ever happened within the program in the past.

FOOTNOTES

- 1) HCFA, Division of the Budget Estimates.
- 2) NGA completed two surveys on Medicaid reimbursement practices in 1982. Summaries of the surveys are presented in the Appendix. The surveys and the state attachments to those surveys serve as the primary source of information for this report.
- 3) U.S. General Accounting Office, Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care, Washington, D.C., July 15, 1982.
- 4) For example see Randy McElhouse, Ira Kaufman, Rand Zitz and Peggy Usitalo, "Nursing Home Reimbursement Study: Final Report, Madison, Wisconsin, Department of Health and Social Services, September 1981; Minnesota State Legislature, Senate Select Committee on Nursing Homes, House Select Committee on Nursing Homes, Final Report, January 1976; New York State Moreland Act Commission on Nursing Homes, Reimbursing Operating Costs: Dollars Without Sense, Albany, New York, Moreland Act Commission, March 1976.
- 5) Interview, Mark Freeland, HCFA.
- 6) Thomas Walsh and Mike Koetting "Patient Related Reimbursement for Long Term Care," Office of Health Finance, Illinois Dept. of Public Health, January 1978.
- 7) State of Washington Nursing Home Reimbursement Regulations.
- 8) Office of Health Systems Management 1982 Residential Health Care Facility Reimbursement Methodology, Albany, New York, New York State Department of Health, 1982.
- 9) William Scanlon, "The Theory of the Nursing Home Market," Inquiry, Spring 1982.
- 10) Randy McElhouse, et al, Nursing Home Reimbursement Study: Final Report.
- 11) Ibid.
- 12) Ibid.
- 13) Moreland Act Commission, Reimbursing Operation Costs: Dollars Without Sense.
- 14) Interview with Paul Allen, Medicaid Director for the Michigan Medicaid program.



APPENDIX A

Changes Made by the 1981 Omnibus Budget Reconciliation Act and the 1982 Tax Equity and Fiscal Responsibility Act

The 1981 Omnibus Budget Reconciliation Act

The OBRA gave the Secretary of DHHS waiver authority to allow states to:

1. Implement a case management system or specialty physician services arrangement which restricts the provider through whom recipients can obtain primary care services.
2. Share savings of cost effective medical care with recipients through expanded service coverage.
3. Allow localities to act as central brokers in assisting recipients in selecting among competing health care plans.
4. Restrict recipient access to cost-efficient providers.

Other changes in Medicaid hospital reimbursement which are relevant to this discussion are:

1. Removal of the requirement that states pay for the reasonable cost of inpatient hospital services in accordance with methods and standards that are developed by the states and reviewed and approved by the Secretary of DHHS.
2. Removal of the requirements that specify how states are to determine their payments for inappropriate inpatient hospital services to patients who require a lower level of care.
3. Addition of the requirement that the state pay for hospital services through the use of rates reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.
4. Addition of the requirement that the states' methods and standards for determining payment rates for hospital services take into account the situation

of hospitals that serve a disproportionate number of low income patients with special needs, and, in the case of hospital inpatients receiving an inappropriate level of care, provide for lower reimbursement rates reflective of the level of care actually received by the patient.

5. Addition of the requirement that states' payment rates for hospital services be reasonable and adequate to ensure that Medicaid patients have reasonable access to inpatient hospital services of adequate quality, taking into account geographic location and travel time.

There were also a number of provisions which were designed to increase Medicaid participation in HMOs:

1. States may enter into prepaid arrangements with entities other than federally qualified HMOs if: 1) the entities make covered services available and accessible to Medicaid recipients to the same extent as they are to other Medicaid eligibles in their areas; and 2) adequate provisions are made by the entity against the risk of insolvency, and in no case the enrollees made liable for debts of the organization;
2. The 50 percent ceiling on Medicaid and Medicare beneficiary enrollment is raised to 75 percent (the Secretary may waive the ceiling entirely for public HMOs);
3. States may establish minimum enrollment periods of up to six months for Medicaid beneficiaries enrolled in federally qualified HMOs, and federal matching payments will be available for that full period even if general Medicaid eligibility is lost;
4. The Secretary is given waiver authority to allow states to share with clients the savings from cost-effective health care delivery methods through the provision of additional services; and

5. The Secretary is required to conduct a study evaluating the extent of, and reasons for, the termination of HMO enrollment by Medicaid recipients.

The Tax Equity and Fiscal Responsibility Act of 1982

This Act contains two provisions that are relevant to this discussion of ways in which Medicaid programs can alter their hospital payment methods in order to save costs. The first of these provisions allows the imposition of some copayments, and the second removes the authority given to the Secretary of DHHS in the 1981 Omnibus Budget Reconciliation Act to grant waivers for capitation and prepayment systems to other than federally qualified health maintenance organizations.

Copayments by Medicaid Recipients:

States may impose nominal copayments for most outpatient services, and higher than nominal copayments for non-emergency services rendered in emergency rooms. The nominality requirement can only be waived for other services in strictly controlled situations within demonstrations. There are a number of restrictions on the population and type of services on which copayments can be charged:

1. No copayments on children under age 18.
2. No copayments on services related to pregnancy.
3. No copayments on services provided to inpatients in SNFs and ICFs who are required to spend all of their income on medical expenses except for the amount exempted under the state standard for personal needs.
4. No copayments on categorically needy HMO enrollees.
5. No copayments on family planning services or emergency services for either categorically needy or medically needy individuals.
6. The state may exempt certain other select groups from copayments.

HMO and Risk Sharing Arrangements:

Under the 1981 Omnibus Budget Reconciliation Act the Secretary of DHHS was given the authority to grant waivers of the requirements of Section 1903(m) of the Social

Security Act, thus allowing states to contract on a risk basis with entities other than federally-qualified or state-certified HMOs. This waiver authority was rescinded in the 1982 Tax Equity and Fiscal Responsibility Act. Any waivers under this authority that were granted with waived arrangements in effect prior to August 10, 1982 are permitted to continue for the approved duration of the waiver. However, the Act makes it clear that this is not intended to affect case management-type contracts, provided they meet the following conditions:

1. Case management is the primary purpose.
2. Hospital services are not provided directly by, or under contract for payment to, the physician or physician group.
3. The physician or physician group receives at least 25% of its gross revenues from non-Medicaid and non-Medicare patients.
4. The Medicaid revenues that the physician or physician group would otherwise receive from the arrangement will not increase more than 20% as a result of a savings accrued from decreases in the utilization of inpatient of hospital and other covered services.
5. Primary care services are available on a 24-hour basis.

The Tax Equity and Fiscal Responsibility Act of 1982 contained some provisions which apply only to the Medicare program, but which could be very useful to states in their efforts to control Medicaid expenditures. The effect of the changes will be to transform the Medicare payment system into a partially prospective payment system with limits on the cost per case. Two limits are to be imposed, beginning with the hospitals' fiscal years which start on or after October 1, 1982. These are discussed below.

Expansion of the Section 223 limitations

Up until now the Section 223 limitations have applied only to the routine cost per day of the hospital, and have had little, or possibly even a negative, effect on controlling the costs of hospitals. These limits are now expanded to apply to the cost per case, and to

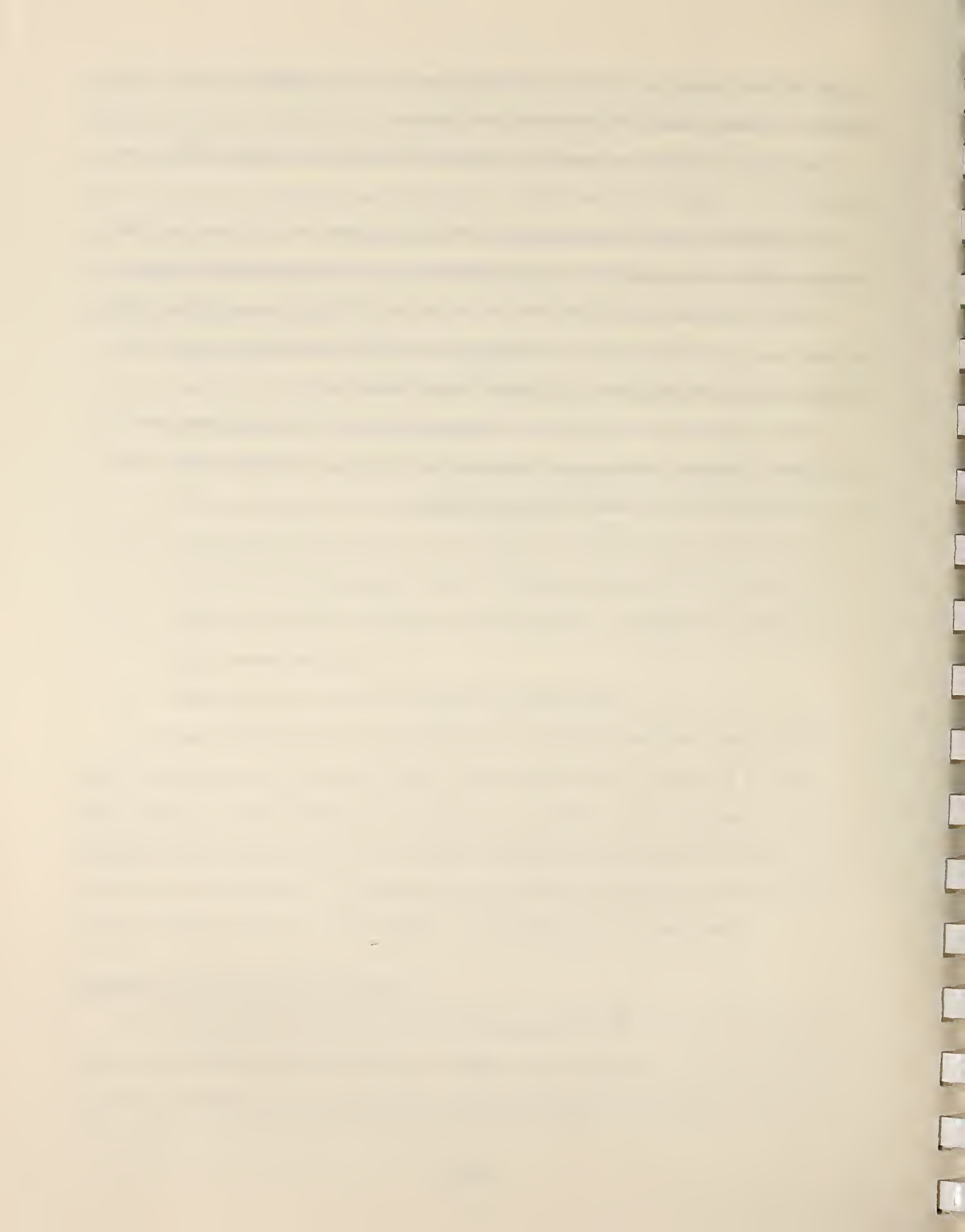
include ancillary costs, which have traditionally been the main culprit in hospital cost inflation. The way in which the limits work is as follows:

The cost per case of the hospital is adjusted for the case mix experienced by the hospital.

The adjusted cost per case is compared with the adjusted cost per case for other hospitals which are determined to be in the same peer group as the hospital under study.

For the first year of the limits, the limit will be set at 120% of the peer group mean cost per case. For the second year the limit will be 115% of the peer group mean, and in the third year the limit will be set at 110% of the peer group mean.

Special adjustments will be made for hospitals which have a disproportionate load of low income or Medicare patients, and for psychiatric hospitals. Non-SMSA hospitals with less than 50 beds will be excluded from the limitations.



APPENDIX B

**SUMMARY CHART OF STATE NURSING HOME
REIMBURSEMENT POLICY CHARACTERISTICS**

AND NGA QUESTIONNAIRE

CHART I CAPITAL

The Value of the Home										State Sets	
Historic Costs				Market Value			Depreciation Permitted				
Historic Costs	From Date of Construction		Replacement Costs	Market Value	Buyer and Seller Must be Unrelated	Price Limits		Dollar Ceiling on Cost per Bed	Straight Line	Accelerated	
	From Date	Last Sale				Other	Other				
AL			Yes					Yes(1)	Yes	Yes	AL
AK											AK
AZ		Yes							Yes	Yes	AZ
AR	Yes										AR
CA	Yes	Yes						Yes(2)	Yes	Yes	CA
CO	Yes										CO
CT	Yes	Yes							Yes	Yes	CT
DE	Yes										DE
DC											DC
FL	Yes	Yes	Yes	Yes			Yes(4)		Yes	Yes(5)	FL
GA	Yes	Yes	Yes(6)					Yes(7)	Yes	Yes	GA
HI	Yes	Yes	Yes	Yes(9)	Yes(10)				Yes	Yes(11)	HI
ID	Yes	Yes(12)							Yes	Yes	ID
IL	Yes		Yes(14)					Yes(15)	Yes	Yes	IL
IN	Yes	Yes							Yes	Yes	IN
IA	Yes	Yes		Yes			Yes(16)		Yes	Yes	IA
KS	Yes	Yes		Yes				Yes(18)	Yes	Yes	KS
KY	Yes	Yes							Yes	Yes(19)	KY
LA											LA
ME	Yes	Yes							Yes	Yes(20)	ME
MD	Yes	Yes							Yes	Yes	MD
MA	Yes		Yes(21)						Yes	Yes	MA
MI	Yes	Yes	Yes(22)		Yes(24)				Yes	Yes	MI
MN	Yes	Yes	Yes(25)			Yes (see 25)		Yes(25)	Yes	Yes(26)	MN
MS	Yes	Yes		Yes	Yes	Yes(27)			Yes	Yes	MS
MO									Yes	N/A	MO
MT											MT
NE	Yes	Yes		Yes	Yes				Yes	Yes	NE
NV	Yes	Yes		Yes	Yes(28)				Yes	Yes	NV
NH	Yes	Yes							Yes	Yes	NH
NJ	Yes	Yes	Yes(29)			(30)			Yes	Yes	NJ
NM	Yes(31)	Yes		Yes					Yes	Yes	NM
NY	Yes	Yes							Yes	Yes(32)	NY
NC	Yes	Yes							Yes	Yes	NC
ND	Yes	Yes							Yes	Yes	ND
OH	Yes	Yes		Yes	Yes(33)	Yes(34)		Yes(35)	Yes	Yes	OH
OK	Yes		Yes(36)						Yes	Yes	OK
OR	Yes	Yes(37)					Yes(38)	Yes(39)	Yes	Yes	OR
PA									Yes	Yes	PA
RI	Yes	Yes		Yes	Yes(40)	Yes(41)			Yes	Yes	RI
SC	Yes	Yes	Yes(42)	Yes	Yes(43)	Yes		Yes(44)	Yes	Yes	SC
SD	Yes	Yes							Yes	Yes	SD
TN	Yes								Yes	Yes	TN
TX	Yes	Yes		Yes	Yes			Yes	Yes	Yes	TX
UT			Yes(45)								UT
VT	Yes	Yes(46)		Yes	Yes(47)	Yes(48)		Yes(51)	Yes	Yes	VT
VA	Yes			Yes	Yes(49)	Yes	Yes(50)		Yes	Yes	VA
WA	Yes	Yes							Yes	Yes(52)	WA
WV	Yes	Yes	Yes					Yes(53)	Yes	Yes(54)	WV
WI	Yes	Yes	Yes					Yes(55)	Yes	Yes	WI
WY	Yes	Yes	Yes						Yes	Yes	WY

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CHART 1 FOOTNOTES
CAPITAL REIMBURSEMENT

1. Alabama: \$13,000, based on historic trends, revised annually.
2. Colorado: Only so far as lease of facility is concerned. Rental costs are limited to a median cost. Median is computed using costs of owned facilities. Rental costs limited by median for year lease entered and increases/decreases in property costs over lease year. (see Regs. 8.446)
3. Connecticut: In limited situations where increase in value for sales is allowed, historic costs are updated to date of sale.
4. Florida: For capital reimbursement purposes, the lower of purchase price, market value, depreciated replacement cost is used.
5. Florida: With special approval, the double declining balance or sum of the years method is used.
6. Georgia: See Regs Ch. 1000, x-9, 1002.5.
7. Georgia: Ch. 1000, pgs. x-1-7, State Health Planning also sets maximum values on the costs of beds.
8. Hawaii: Cost may not exceed lower of depreciated replacement or market value.
9. Hawaii: For donated assets.
10. Hawaii: Buyer and seller may not be related by common ownership or control.
11. Hawaii: a) For assets acquired before 8/70, declining balance (up to 200% of straight-line rate) or sum of year's digits. b) For assets acquired after 7/70, declining balance (up to 150% of straight-line rate) under limited circumstances. See regs HIM 15-1, Sec. 116C.
12. Idaho: Yes, if original owner is current owner.
13. Illinois: The historic cost at the latter of the date of construction or date of last purchase prior to July 1, 1977 is used. (See attached rate calculation guide.)
14. Illinois: The undepreciated historic cost is inflated to the rate year according to the change in construction cost index.
15. Indiana: \$17,900 per bed is allowed, adjusted semi-annually in accordance with the construction portion of CPI.
16. Iowa: Lower of appraised value (depreciated) or purchase price.
17. Kansas: See subparagraph (bb) and (cc) pages 6 and 7 of Sec. 30-10-12 and (iv) on page 11 of Sec. 30-10-13.
18. Kansas: The property cost center is limited to the amount representing the 85th percentile of the property costs of providers participating in the program. The current limits are: SNF \$6.72, ICF \$5.59, ICF/MR \$7.21.

19. Kentucky: If the cash flow of a facility warrants it, it may receive permission to utilize 150% declining balance.
20. Maine: Only on energy efficient improvements.
21. Massachusetts: Since 1976, facilities valued at 1976 rate.
22. Michigan: Cost limited to lesser of: 1) purchase price, b) depreciated replacement cost, or c) fair market value.
23. Michigan: Independent appraiser chosen by provider.
24. Michigan: See Medicare principles of reimbursement.
25. Minnesota: When the appraised value of home under depreciated replacement costs less than purchase price, investment per bed limit adjusted annually based on year built or purchased. 1982: single bed--\$39,887, 2 or more beds in a room--\$26,541.
26. Minnesota: If principle payments amortized evenly over term of loan not less than 20 years.
27. Mississippi: Certificate of need review by Health Planning Agency
28. Nevada: No common ownership or control.
29. New Jersey: Appraised in '77 replacement costs less wear and tear subject to reasonableness limits on square feet and appraised value per square foot.
30. New Jersey: 23 rules are established on a dual trade, historical (unscreened) versus capital facilities allowance (screened).
31. New Mexico: Although value of depreciable assets are based upon historic cost at construction or acquisition with the following exceptions:
 - a. If an existing facility is leased or sold, the allowable facility cost of the new provider is limited to the lesser of actual costs or the 80th percentile facility costs in the previous year of all participating providers who provide the same level of care which own and operate their own facilities and do not incur rental expense which is more than 20% of total facility costs.
 - b. Newly constructed facility costs are limited to those applicable to the median cost of constructing a nursing home as listed in an index acceptable to the Department. At present the Construction Cost Guide published by Robert S. Means Co. is used.
32. New York: For voluntary public facilities only.
33. Ohio: Lack of common ownership/control and/or lack of family relationship.
34. Ohio: Unrelated buyer may revalue assets based upon purchase price, but is subject to screening.
35. Ohio: Maximum dollar value ranges from \$2.50 to \$6.45 per day based on date of original nursing home licensure and original per bed construction costs.

36. Oklahoma: January 1, 1977, for assets acquired since this date.
37. Oregon: Only for original owner, not subsequent owners.
38. Pennsylvania: Lesser of purchase price, fair market value by 2 independent appraisers less any straightline depreciation; new facilities costs minus start up costs.
39. Pennsylvania: \$22,000 per bed and fixed equipment.
40. Rhode Island: Blood, marriage, or financial interest.
41. Rhode Island: Limited to the lower of a) fair market value, b) purchase price, c) reproduction costs depreciated over useful life of the assets, d) original cost plus a return of 5% per year from date of acquisition.
42. South Carolina: Medicare guidelines limit maximum recognition of cost at replacement value.
43. South Carolina: Medicare principles.
44. South Carolina: Cost of capital limited to \$7.79 per patient day.
45. Utah: Property recognized in the rate as of 3/27/81. Approximately 40% cost inflated by CIP-U less mortgage index each year.
46. Vermont: Cost to purchaser at date of purchase by the owner.
47. Vermont: Related by blood, marriage, corp-subsidaries partners.
48. Vermont: Limit is agreed upon sales price in the sales agreement, or the appraisal value, whichever is less.
49. Virginia: Buyer and seller aren't business or family relative.
50. Virginia: The lower of 1, 2, 3 subject to Dodge Construction Systems cost limitations.
51. Virginia: Maximum is established each year in January for building and fixed equipment costs based upon Dodge Construction System cost as of June 1, 1983, the amount will be \$22,965.00 per bed plus 7% for financing costs.
52. Washington: On equipment only, declining balance, sum of the year's digits. Declining balance is limited to 150% of straightline.
53. West Virginia: Per patient date rate lid on depreciation, interest and lease based upon multiple regression adjustment. Limit for difference in construction age and type.
54. West Virginia: On equipment only declining balance, sum of teh year's digits. Declining balance limited to 150% of straightline.
55. Wisconsin: \$17,600/1977 amount, indexed to current sum by Engineering News Record from year of facility construction.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and the role of the accounting department in ensuring the integrity of the financial statements.

2. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

3. The second part of the document focuses on the role of the management team in overseeing the financial performance of the company and the importance of having a clear understanding of the company's financial position.

4. It also discusses the need for transparency and communication with stakeholders and the importance of having a strong corporate governance framework in place.

5. The third part of the document discusses the role of the board of directors in overseeing the financial performance of the company and the importance of having a strong internal control system in place to prevent fraud and errors.

6. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

7. The fourth part of the document discusses the role of the accounting department in ensuring the integrity of the financial statements and the importance of having a strong internal control system in place to prevent fraud and errors.

8. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

9. The fifth part of the document discusses the role of the management team in overseeing the financial performance of the company and the importance of having a clear understanding of the company's financial position.

10. It also discusses the need for transparency and communication with stakeholders and the importance of having a strong corporate governance framework in place.

11. The sixth part of the document discusses the role of the board of directors in overseeing the financial performance of the company and the importance of having a strong internal control system in place to prevent fraud and errors.

12. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

13. The seventh part of the document discusses the role of the accounting department in ensuring the integrity of the financial statements and the importance of having a strong internal control system in place to prevent fraud and errors.

14. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

15. The eighth part of the document discusses the role of the management team in overseeing the financial performance of the company and the importance of having a clear understanding of the company's financial position.

16. It also discusses the need for transparency and communication with stakeholders and the importance of having a strong corporate governance framework in place.

17. The ninth part of the document discusses the role of the board of directors in overseeing the financial performance of the company and the importance of having a strong internal control system in place to prevent fraud and errors.

18. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

19. The tenth part of the document discusses the role of the accounting department in ensuring the integrity of the financial statements and the importance of having a strong internal control system in place to prevent fraud and errors.

20. It also highlights the need for regular audits and the importance of having a strong internal control system in place to prevent fraud and errors.

CHART 2
CAPITAL REIMBURSEMENT

	Depreciation Must Be Funded	Useful Life			Interest Expenses Recognized	State Sets the Rate It Will Pay	Actual Expenses Paid	Interest Expenses Reimbursed			
		30 Years	35 Years	40 Years				Prevailing Rates	Prevailing Rates to a Ceiling	Medicare Rate of Return	Other
AL				Yes	Yes	Yes		Yes(1)			
AK											
AZ											
AR				Yes	Yes		Yes	Yes			
CA					Yes		Yes				Yes(3)
CO							Yes				
CT		Yes			Yes		Yes				
DE					Yes			(4)		Yes	
DC							Yes	Yes(6)			
FL			Yes(5)		Yes		Yes	Yes(8)	Yes(9)		
GA		Yes		Yes	Yes		Yes				Yes(11)
HI		Yes			Yes		Yes				
ID		Yes			Yes		Yes	Yes(12)			(13)
IL					Yes						Yes(15)
IN					Yes		Yes	Yes	Yes		
IA			Yes		Yes		Yes				Yes(17)
KS					Yes		Yes				Yes(18)
KY			Yes		Yes		Yes				
LA		Yes									
ME			Yes	Yes	Yes	Yes	Yes	Yes			
MD			Yes	Yes	Yes	Yes	Yes	Yes			
MA				Yes	Yes	Yes	Yes	Yes(19)			
MI					Yes		Yes				
MN			Yes		Yes	Yes	Yes	Yes(22)			
MS					Yes						
MO					Yes						
MT					Yes		Yes	Yes			
NE				Yes	Yes	Yes	Yes	Yes			
NV					Yes		Yes	Yes(25)			
NH					Yes		Yes		Yes		
NJ					Yes		Yes				
NM	Yes(29)			Yes	Yes	Yes(30)	Yes	Yes(28)			
NY					Yes		Yes	Yes(31)			
NC					Yes		Yes			Yes	Yes(34)
ND					Yes		Yes				
OH			Yes		Yes		Yes		Yes(36)		
OK					Yes		Yes				
OR		Yes	Yes		Yes	Yes(40)	Yes	Yes			Yes(39)
PA				Yes	Yes		Yes		Yes(41)		
RI					Yes		Yes		Yes(43)		
SC		Yes			Yes		Yes	Yes(45)			
SD					Yes		Yes	Yes(46)			
TN					Yes		Yes				
TX			Yes		Yes		Yes	Yes			
UT					Yes		Yes				Yes(49)
VT		Yes		Yes	Yes		Yes				Yes(51)
VA					Yes		Yes		Yes(53)		
WA	Yes				Yes		Yes		Yes		
WV	Yes				Yes		Yes				
WI		Yes	Yes		Yes		Yes	Yes		(54)	
WY		Yes			Yes		Yes	Yes			

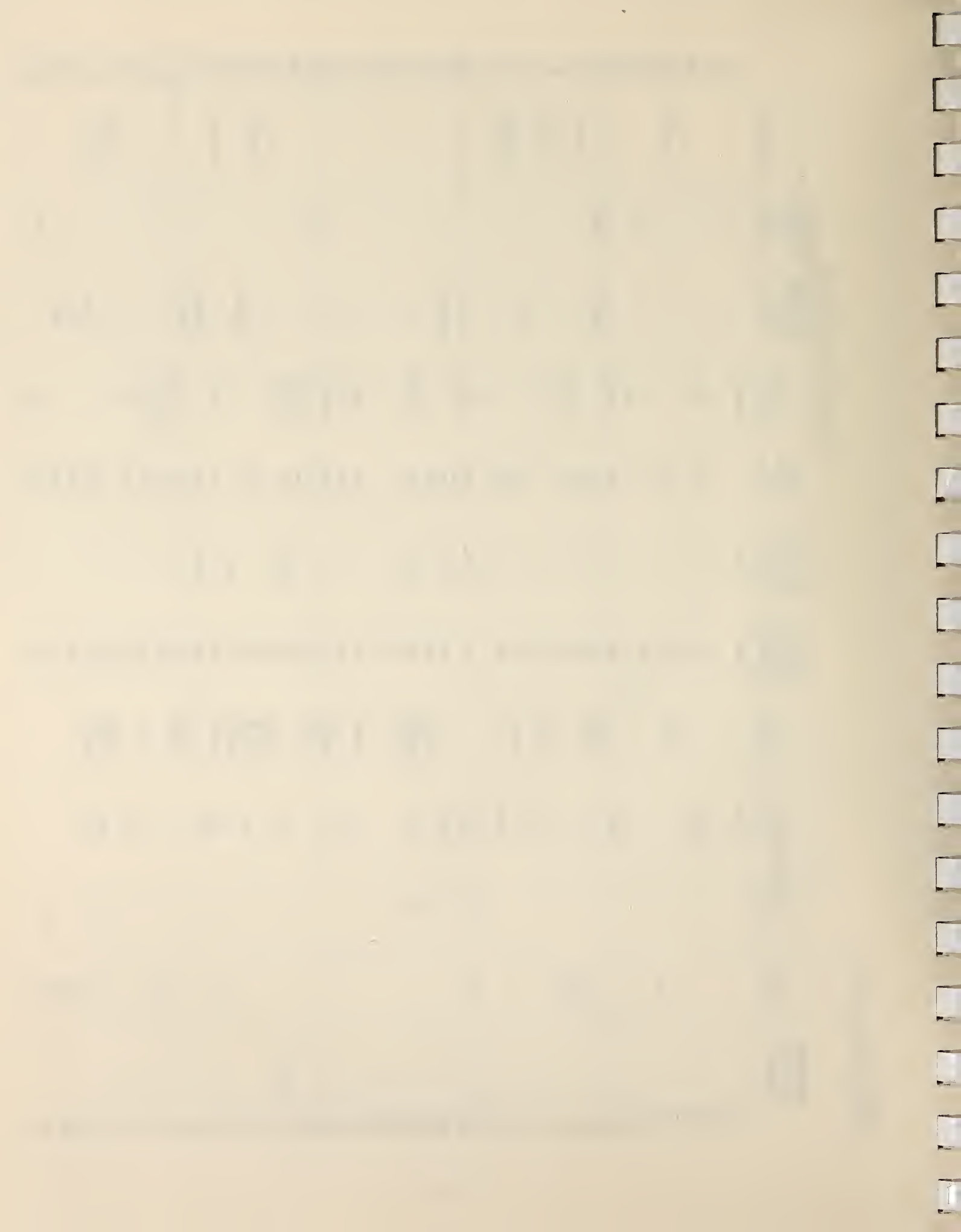


CHART 2 FOOTNOTES
CAPITAL REIMBURSEMENT

1. Alabama: Alabama doesn't govern or try to control rates of interest. We reimburse historic costs based on actual transactions and the rate of interest at that time.
2. Colorado: Depends on age of facility at the time of the purchase.
3. Colorado: Amount paid except that related parties receive to extent of prime rate additional due to refinancing disallowances.
4. District of Columbia: Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing of the time the loan was made will be recognized.
5. Florida: Per AHA guidelines.
6. Florida: The rate of debt instrument is used.
7. Georgia: If a transaction, the life is determined by the replacement cost appraisal; otherwise, use AHA guidelines for depreciation.
8. Georgia: Houses grouped by age and maximum property costs permitted.
9. Georgia: We use 1½ times the FHI rate; we currently have frozen it at 15.188% for return on equity.
10. Hawaii: 25 years masonry, woodframe residence, masonry or wood frame.
11. Hawaii: Necessary and proper HIM-15-I, Sec. 202.2 and 3.
12. Idaho: Reasonableness based upon intended use, i.e. – capital improvement vs. operating. Also based upon availability of other funds as demonstrated by rates obtained by similar facilities.
13. Illinois: A rate of return of 11.1% is paid on the updated investment in the nursing home. This covers all interest and depreciation expense in most cases but there is no guarantee that all interest expense will be paid.
14. Indiana: Provider specific subject to reasonableness.
15. Indiana: Maximum allowable interest rate is 1½% above the Federal Home Loan Mortgage Corporation whole loan purchase multi-family rate.
16. Kansas: Varies: usually the same estimated life used for tax purposes.
17. Kansas: See Section 30-10-13-KS Ad. Regs., beginning pg. 12, 5(A), 5(B), 5(C), 5(D), 5(E) and 5(F).
18. Kentucky: Whatever the interest rate the home is charged allowed.
19. Massachusetts: The mean of each group of facilities (SNF freestanding, ICF 40 beds, ICF 40 beds) + standard deviation above mean is ceiling.

20. Michigan: Must be in compliance with S 104.17 of provider reimbursement manual.
21. Minnesota: On sale of existing facility % of useful life applied to inputted 35 years.
22. Minnesota: What a borrower would have to pay in arms-length transaction in the money market.
23. Nebraska: By type of construction 50-30 years.
24. New Hampshire: Depends on type or construction. We use life year guidelines described in HIM 15, Section 104.17 and CCH Medicare and Medicaid Guide. Paragraphs 4695 and 4696.
25. New Hampshire: Rate charge by a bona fide lending institution according to the terms of an agreement entered into an arm's length transaction.
26. New Jersey: New construction - 40 years if constructed after 1959. Old construction - 25 years if constructed prior to 1960.
27. New Mexico: IE 1. through 4. - useful lines of depreciable assets are considered on an individual basis using the lines published in the AHA Audit Guide as guideline.
28. New Mexico: By comparison on an individual basis with rates available in the state on similar loans.
29. New York: Voluntary facilities only are required to fund the difference between depreciation and mortgage principle plus capital improvements. If depreciation is not funded, no reimbursement for depreciation is made.
30. New York: According to the market condition at the time financing is secured; in most cases, not to exceed FHA rate.
31. New York: Justification must be submitted by the home stating that this is the best rate which could be obtained. In most cases, FHA rate is guideline.
32. North Carolina: We use variable life based on the AHA standards published as "Estimated Useful Lives of Depreciable Assets."
33. North Dakota: 40 year useful life except on sale when useful life is used.
34. North Dakota: Actual as supported by an evidence of agreement that funds were borrowed and that repayment of interest and repayment of the funds are required.
35. Ohio: Building has 40 year useful life. All other equipment has useful life prescribed in IRS guidelines.
36. Ohio: Depreciation, interest, and any lead.
37. Oklahoma: Each home has discretion to estimate the useful life.
38. Oregon: If leased, the lessor of estimated useful life and lease term.
39. Oregon: If between related parties limited to lessee of rate charged and current commercial rate less 10% rate portion applied in the ROE computation.

40. Pennsylvania: Maximum rate 3 points above prime on allowable costs.
41. Pennsylvania: Remains at 3 points above prime at the time the funds are borrowed.
42. Rhode Island: Wood-25 years, Wood and Masonry-33 years, Masonry and Steel-40 years.
43. Rhode Island: Interest and depreciation limited to a maximum of 70th percentile of arrayed facilities of same level of care.
44. South Carolina: IRS guidelines depending on type of structure.
45. South Carolina: Necessary and prudent as well as reasonable.
46. South Dakota: Rate charged by lending agency.
47. Tennessee: Use American Hospital Association Guidelines which is based on type of construction.
48. Utah: Useful life may vary according to HIM-15 or prior agreement. At present we don't permit changes in the useful fee or in the depreciation expense.
49. Utah: Modified flat rate does not recognize changes in the mortgage – other interest costs may be recognized in data base.
50. Vermont: We use the Estimated Useful Lives of Depreciable Hospital Assets, 1978 ed., by the American Hospital Association.
51. Vermont: Reasonable is determined on case-by-case basis.
52. Virginia: For old facilities the average of the appraised value + 40 years.
53. Virginia: Limits set by maximum rate set by the Virginia Housing Authority.
54. Wisconsin: 1.25×3 year composit average cost of Hospital Investment Trust Fund.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the statistical analysis performed.

3. The third part of the document presents the results of the study. It includes a series of tables and graphs that illustrate the findings of the research. The data shows a clear trend of increasing activity over time.

4. The fourth part of the document discusses the implications of the findings. It suggests that the results have significant implications for the field of study and may lead to further research in this area.

5. The fifth part of the document concludes the study. It summarizes the main findings and provides a final statement on the importance of the research.

CHART 3
CAPITAL REIMBURSEMENT

	Interest on Negative Net Equity		If Yes to: Interest on Negative Net Equity Paid		Penalties for Negative Net Equity Interest Expenses	Value of Homes Set By				Sales of Home Reimbursed	Depreciated Replacement Costs	Value of Homes Set By			Depreciation Recapture Provisions	Incentives Not to Sell
	Paid	Net Equity	All Interest Expenses Paid	Interest Expenses to a Ceiling		Income Value	Assessed Value	Market Value	Other			Income Value	Assessed Value	Market Value		
AL					(1)	Yes	Yes			Yes	Yes(2)				Yes(3)	AL
AK																AK
AZ									Yes(4)	Yes						AZ
AR																AR
CA																CA
CO										Yes						CO
CT	Yes		Yes			Yes		Yes	Yes(6)	Yes						CT
DE															Yes	DE
DC																DC
FL	Yes		Yes			Yes		Yes	Yes(7)	Yes	Yes	Yes			Yes(8)	FL
GA						Yes	Yes			Yes	Yes					GA
HI	Yes		Yes		Yes(10)	Yes		Yes(14)	Yes(11)	Yes					Yes(12)	HI
ID						Yes				Yes	Yes(16)				Yes(15)	ID
IL						Yes			Yes							IL
IN						Yes			Yes							IN
IA	Yes		Yes			Yes	Yes	Yes		Yes					Yes(18)	IA
KS	Yes		Yes	Yes(20)	Yes(21)	Yes		Yes	Yes	Yes					Yes(22)	KS
KY	Yes		Yes	Yes(23)		Yes			Yes(24)							KY
LA						Yes			Yes(26)							LA
ME	Yes		Yes		Yes(25)	Yes			Yes(29)						Yes(27)	ME
MD						Yes										MD
MA	Yes		Yes(32)		Yes(33)	Yes		Yes(35)	Yes(36)	Yes	Yes(38)				Yes(30)	MA
MI				Yes		Yes			Yes	Yes					Yes(37)	MI
MN															Yes(39)	MN
MS				Yes	Yes				Yes(41)						Yes(42)	MS
MO																MO
MT								Yes		Yes					Yes(44)	MT
NE	Yes		Yes			Yes		Yes		Yes					Yes(45)	NE
NV						Yes				Yes					Yes(46)	NV
NH						Yes			Yes(sales price)							NH
NJ	Yes			Yes(47)		Yes	Yes			Yes						NJ
NM						Yes			Yes(48)						Yes	NM
NY					(49)										(50)	NY
NC			Yes(51)			Yes		Yes	Yes(53)		Yes(52)				Yes	NC
ND						Yes			Yes(54)							ND
OH	Yes			Yes(55)		Yes		Yes(56)		Yes					Yes	OH
OK						Yes		Yes		Yes						OK
OR						Yes		Yes		Yes					Yes	OR
PA						Yes			Yes(58)							PA
RI	Yes			Yes		Yes			Yes(59)						Yes(60)	RI
SC	Yes		Yes			Yes					Yes				Yes	SC
SD	Yes		Yes			Yes		Yes(62)		Yes						SD
TN	Yes					Yes		Yes	Yes(64)						Yes(63)	TN
TX	Yes		Yes			Yes										TX
UT																UT
VT	Yes		(65)			Yes		Yes(66)	Yes(67)							VT
VA	Yes		Yes	Yes		Yes			Yes(69)						Yes	VA
WA	Yes			Yes(71)		Yes			Yes(72)							WA
WV	Yes			Yes(73)		Yes			Yes(74)							WV
WI	Yes		Yes			Yes			Yes(75)							WI
WY								Yes(reasonable)								WY

CHART 3 FOOTNOTES
CAPITAL REIMBURSEMENT

1. Alabama: Not unless loans were made to pay for unallowable expenses and also depleted working capital. In that case interest would be non-allowable.
2. Alabama: Replacement cost value determined by Alabama Medicaid, based on a per bed maximum.
3. Alabama: Medicaid portion reimbursed through per diem rate is recaptured for periods subsequent to July 1, 1977, limited to the gain on the sale or recapture, whichever is less.
4. Arkansas: Last sale between unrelated parties, (5% common ownership or more is related party).
5. Arkansas: Class rates 80th % incentive not to sell, if exceed rate.
6. Connecticut: In limited situations value of home increased at time of sale not to exceed depreciated value determination by Dodge Construction Index.
7. Florida: Lower of purchase price, market value, or depreciated replacement costs.
8. Florida: Gain on sale is subject to the recapture provision of the provider reimbursement manual, HIM-15.
9. Georgia: Incentive ceiling .40¢ ppd. ceilings set in properly, one step up in 10 year period; formula takes into account ROE (11.313%)¢ present value of lease.
10. Hawaii: Interest expenses attributed to negative net equity are not reimbursed.
11. Hawaii: Sales price as per HIM 15-I, See Section 104.14B.
12. Hawaii: See regs Section 130--If the sale results in a gain, the amount of the gain is included in the determination of allowable cost and is limited to the amount of depreciation previously included in allowable costs.
13. Hawaii: Provision described in (12) above is incentive if his facility has appreciated, to avoid repayment of depreciation previously included in allowable costs.
14. Idaho: Purchase price supplemented by appraised documents.
15. Idaho: Sale occurs less than 5 years from date of acquisition recapture 100% from buyer. Sliding scale at 10% per year so that at 15 years, no recapture at all. Recapture will take place at the rate of 20% of original amount per year.
16. Illinois: When there is no guarantee that all interest expense will be paid a ceiling is placed upon the price to be recognized. This is based upon the undepreciated cost prior to 7/1/77 as updated for inflation.
17. Illinois: In most cases the rate will be the same for the new owner as the old owner was receiving.

18. Iowa: Any depreciation claimed since July 1, 1980, must be deducted.
19. Iowa: If the facility is fully depreciated we have no provision for ROE or investment.
20. Kansas: Property cost center limit--See item B on p. 1.
21. Kansas: If interest expense causes the property cost to exceed cost of center limit.
22. Kansas: See subparagraph (iii) gain on disposal of assets on page 10 of Sec. 30-10-13, Ks. Ad. Reg.
23. Kentucky: A maximum per diem rate is established for all homes.
24. Kentucky: .667% of gain per month will be recognized as increase of depreciable historic cost.
25. Maine: Interest on excess financing not reimbursed.
26. Maine: Lower of Fair Market Value, replacement cost adjusted for straight line depreciation, sellers historical cost inflated by the CPI Index for all items from the date of purchase to date of sale, or selling price.
27. Maine: Depreciation paid on behalf of Medicaid patients recaptured to the extent of the gain on the sale.
28. Maine: Credits against depreciation recapture given for facilities owned more than 8 years, increased if facility owned over 15 years, and if owned over 25 years the depreciation recapture is eliminated.
29. Maryland: Lower of market value, replacement costs, or sales price. Lower of reproduction cost minus straight line depreciation is fair market value or sales price.
30. Massachusetts: Until 1968 recapture against sale.
31. Massachusetts: No step up in base, no recognition of "fair market value."
32. Michigan: If resultant plant cost component is less than the plant cost limit.
33. Michigan: If plant costs exceed the plant cost limit, excess costs are not allowed.
34. Michigan: Only one sale is recognized (most recent) per five year period and costs paid must be less than (sales/resales) plant costs limit (determined as the provider's prior plant cost limit with the interest expense component revised to reflect market interest rates at the time of the sale).
35. Michigan: See 42 CFR-405.415(b)(2).
36. Michigan: The lesser of depreciated replacement cost, the market value, or the purchase price.
37. Michigan: To full extent allowed by Medicare principles of reimbursement.
38. Minnesota: Value based on the lesser of the purchase price or the appraisal.

39. Minnesota: The recapture is the lesser of the gain on sale or the depreciation expense since the adoption of DPN Rule 49 (11-02-72) Gross recapture is factored for the welfare portion to determine the net recapture. The net recapture is reduced by 1% for each month of continuous ownership since the date of acquisition.
40. Minnesota: Reduction in recapture and increase in return on equity function of years of ownership.
41. Mississippi: Certificate of Need Review by Mississippi Health Care Commission, a separate autonomous health planning agency.
42. Mississippi: In part according to provisions of HIM-15 for periods under prospective rates.
43. Mississippi: ROE and adequate rates
44. Nebraska: Lessor for Medicaid paid for depreciation on Medicaid share of gain.
45. Nevada: Selling price less all previous declared depreciation.
46. New Hampshire: If calculated according to HIM-15, Sec. 132.
47. New Jersey: Medicare rate of return.
48. New Mexico: Allowable depreciation to new provider limited to the 80th percentile of per diem depreciation costs of other similar providers in the state.
49. New York: No interest or equity reimbursed.
50. New York: Sales are based on unreimbursed value of the original historical cost.
51. North Carolina: Payment subject to indirect rate limit; allowable amount subject to reasonableness.
52. North Carolina: Or market value, whichever is lower. Replacement cost is determined and home is depreciated based on age from date of construction using straight line method.
53. North Carolina: Lower of market value or depreciated replacement.
54. North Dakota: Lower of replacement fair market value, price paid. Lower of (1) current reproduction cost of assets, depreciated on a straight line basis over its useful life to the time of sale, (2) price paid by the purchaser in fair market value of the facility at the time of sale.
55. Ohio: Interest on capital assets identified in #35, Chart I. Interest on working capital is part of the flat rate for administrative and general services.
56. Ohio: New owner values at purchase price. If both assets and liabilities are purchased, considered ongoing business and assets may not be revalued.
57. Ohio: Recapture provision limited. Recovery provision for 10 years. Ceiling based upon original dated cost of construction is often too low to appeal to prospective buyers.

58. Pennsylvania: The value of a purchased facility shall be the lesser of the purchase price or the fair market value based on the lesser of at least two bonafide appraisals at the time of sale less any straight line depreciation by the prior owner.
59. Rhode Island: See I.A.3.b. (Chart 1, #41).
60. Rhose Island: Depreciation reimbursed to a provider from 1/1/72 through 12/31/76-- full depreciation recovery. From 1/1/77 through 12/31/81 full depreciation recovery less 1½% credit for each year. From 1/1/82 through future periods, full depreciation recovery less 5% credit for each year.
61. Rhode Island: Recapture of depreciation plus limitations on sale price as addressed at I.A.3.b. acts as incentive not to sell.
62. South Dakota: Selling price is used for depreciation purposes.
63. Tennessee: See page 65.030, Item 9 of the Rules of Comptroller of the Treasury Administrative Office of Comptroller Health Services Division, Attachment 1.
64. Texas: Based upon acquisition cost to purchaser.
65. Vermont: No, only interest expense on nonrelated purity debt is reimbursed.
66. Vermont: Independent appraisal but not more than the agreed upon purchase price in the sales/purchase agreement.
67. Vermont: Lower of purchase price or appraised value.
68. Virginia: If owned by the Seller for 5 years or more + if related parties are not involved.
69. Virginia: The lower of appraised value, purchase price or construction cost limitation.
70. Utah: Profitability and Equity Control.
71. Washington: Long term debt interest is subject to the property rate reimbursement lid (I.B.). Working capital interest is included in the administration's cost area which is subject to an 85th percentile lid.
72. Washington: Depreciation based upon sale price plus interest subject to a lid based upon a regression performed on all contractors' property expense.
73. West Virginia: Long-term care debt limited by property reimbursement lid (IB) working capital under administrative lid at 85th percentile.
74. West Virginia: Depreciation based upon sale price plus interest subjected to a lid based upon a regression performed on all contractors property expense.
75. Wisconsin: Depreciation doesn't change (original cost). Interest expense reflect current cost, lease expense allowed up to a lease maximum.

CHART 4
CAPITAL REIMBURSEMENT
PROFITS AND RETURN ON EQUITY

Profits and Return on Equity									
Capital Reimbursement				Federal Tax					
Lease Payments Reimbursed				Laws					
Lease Payments Reimbursed	State Sets Limit on Payments	Lease Must be of a Minimum Duration	Leasehold Rights Reimbursed	Changed Reimbursement	Profits are Reimbursed	Fixed Fee Per Patient Pay (PPD)	Variable Fee PPD to Maximum	Return on Equity Paid	Rate of Return
AL	Yes	Yes(1)						Yes	Yes(2)
AK									
AZ									
AR	Yes	Yes(3)							
CA	Yes	Yes							
CO	(4)								
CT	Yes							Yes	
DE									
DC					Yes	Yes(5)			
FL	Yes							Yes	
GA	Yes	Yes	Yes(6)		Yes		Yes(7)	Yes	Yes(8)
HI	Yes	Yes(9)						Yes	
ID	Yes	Yes(10)			Yes		Yes(11)		
IL	Yes	Yes(12)							
IN	Yes				Yes		Yes		
IA	Yes	Yes(13)			Yes		Yes(14)		
KS	Yes	Yes(15)							
KY	(16)				Yes		Yes(17)		
LA									
ME	Yes	Yes(18)	Yes(25 yrs)					Yes	Yes(19)
MD	Yes				Yes		Yes		
MA	(20)							Yes(21)	Yes
MI	Yes(22)	Yes(23)	(24)		Yes		Yes(25)	Yes(26)	
MN	Yes	Yes(27)			Yes		Yes	Yes	Yes
MS	Yes	(28)					Yes(29)	Yes	
MO								Yes	Yes
MT							Yes(30)		
NE	Yes				Yes			Yes	Yes(31)
NV	Yes							Yes	Yes(32)
NH	Yes								
NJ	Yes	Yes(33)						Yes	
NM	Yes				Yes		Yes(35)		
NY	(36)							Yes	
NC	Yes	Yes						Yes(37)	Yes(38)
ND	Yes							Yes	Yes(8½%)
OH	Yes	Yes(39)			Yes		Yes(40)	Yes	Yes(41)
OK	Yes	Yes(ave. per diem)							
OR	Yes	Yes(42)			Yes		Yes(43)	Yes	Yes(44)
PA	Yes	Yes(45)			Yes		Yes(46)		
RI	Yes	Yes(47)	Yes(48)		Yes		Yes(49)		
SC	Yes	Yes(50)			Yes		Yes(51)	Yes	
SD	Yes							Yes	Yes(9% on net equity)
TN	Yes				Yes		Yes(52)	Yes	
TX	Yes								
UT	Yes	Yes(53)			Yes		Yes	Yes(54)	
VT	Yes							Yes	
VA	Yes	Yes(55)	Yes(56)		Yes			Yes	Yes(10%)
WA	Yes	Yes(57)						Yes	Yes
WV	Yes	Yes(58)						Yes	
WI	Yes	Yes(59)	(60)		Yes		Yes(61)	Yes	Yes(62)
WY	Yes				Yes		Yes(63)		

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific requirements for record-keeping. It states that all transactions must be recorded in a timely and accurate manner, and that the records must be maintained for a minimum of five years.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It states that the auditor must perform a thorough review of the records and must report any discrepancies to the appropriate authorities.

4. The fourth part of the document discusses the consequences of failing to maintain accurate records. It states that individuals or organizations that fail to comply with the record-keeping requirements may be subject to fines, penalties, and even criminal prosecution.

5. The fifth part of the document discusses the importance of training and education in ensuring compliance with the record-keeping requirements. It states that individuals involved in the financial system must receive appropriate training and education to ensure that they are able to maintain accurate records.

6. The sixth part of the document discusses the importance of internal controls in preventing fraud and ensuring the accuracy of the records. It states that organizations must implement strong internal controls to minimize the risk of fraud and to ensure that all transactions are properly recorded.

7. The seventh part of the document discusses the importance of transparency and accountability in the financial system. It states that all transactions must be transparent and that individuals and organizations must be held accountable for their actions.

8. The eighth part of the document discusses the importance of ongoing monitoring and evaluation of the record-keeping system. It states that the system must be regularly reviewed and updated to ensure that it remains effective and efficient.

9. The ninth part of the document discusses the importance of cooperation and communication between all parties involved in the financial system. It states that individuals and organizations must work together to ensure that the record-keeping system is properly implemented and maintained.

10. The tenth part of the document discusses the importance of the record-keeping system in supporting the overall goals of the financial system. It states that the system is essential for the stability and integrity of the financial system and for the ability to detect and prevent fraud.

CHART 4

1. Alabama: Net lease: 12% of depreciated replacement value which is based on a per bed limit maximum.
2. Alabama: 112.5% of Medicare return.
3. Arkansas: I 2a - cost to lessor.
4. Connecticut: Facilities are reimbursed for property costs based on the fair rental value system whether owned or leased.
5. District of Columbia: Total cost divided by the number of days equal the per diem rate multiplied by nine percent (9%) profit factor.
6. Georgia: HIM requirements, cap on property cost center for total costs and not on the leasehold rights individual accounts.
7. Georgia: See Ch. 100, pages x-6, x-7.
8. Georgia: Frozen at 15.188%.
9. Hawaii: If lease is "virtual purchase" HIM-15-I, Sec. 1103.1 maximum what would have been paid to owner.
10. Idaho: New leases are based upon owners cost = depreciation plus interest; old leases are based upon existing rates plus a reasonable annual increase as determined by a lease cost index.
11. Idaho: Efficiency incentive paid at 25% of difference between homes operating cost and percentile cap up to \$1.50 per day maximum.
12. Illinois: A ceiling is set at 150% of the median per diem lease cost for a geographic area.
13. Iowa: Actual owners expense or \$500 per bed currently revising this policy.
14. Iowa: If costs are below the maximum, an incentive factor is paid. Incentive is the rate that is $\frac{1}{2}$ the difference of the 44th and 78th percentiles of facility costs.
15. Kansas: See prev. ref. Property Cost Ctr. limitation.
16. Kentucky: Based on historic cost unless lease was entered into before beginning of prospective reimbursement system.
17. Kentucky: 12.5% of cost per day up to a maximum of \$2.25.
18. Maine: Limited to cost of ownership.
19. Maine: 10% on annual average equity.
20. Massachusetts: Medicaid reimburses for actual costs.

21. Massachusetts: Calculated by using the net book value of the fixed assets minus long term liabilities.
22. Michigan: If lease contracted prior to 9/1/73.
23. Michigan: \$2.50 ppd, determined as the median (rounded) lease expense in 1983.
24. Michigan: Maybe: leases prior to 9/1/73, "rights" might have been included in lease cost; leases entered after 8/31/73, only the costs of interest depreciation and property taxes are reimbursed up to plant cost limit.
25. Michigan: "Plant profit" consists of up to 50¢ ppd of the difference between the plant cost and the classwide plant cost 80th percentile. "Variable profit" consists of up to \$1.00 ppd. of the difference between the variable costs and the classwide variable cost 80th percentile.
26. Michigan: In lieu of "plant profit."
27. Minnesota: The rental fee cannot exceed the total amount it would pay to the owner of the facility as interest, depreciation, and investment allowance.
28. Mississippi: Subject to certificate of need review.
29. Mississippi: Up to \$2.00/day to extent projected rate does not exceed class minimum.
30. Nebraska: Up to \$1.00 for profit, .50¢ for non-profit gov. (other than state-owned) for amounts under a capture, capture established to cover a percentile of Medicaid days. Percentile can change from year to year but will not go below 65 percentile/proposed to start 1/1/83.
31. Nebraska: 1-½ times the average Hospital Trust Fund rate set annually/current proposed to end 7/31/81.
32. Nevada: Two times the average interest rate on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund.
33. New Jersey: Reasonable appraised value.
35. New Mexico: 50% of the amount per diem which the providers total cost per diem is less than the current maximum reimbursement per diem rate adjusted for the providers' rate of cost increase compared with the increase in C.P.I.
40. Ohio: General and administrative actual costs + \$2.00 up to a flat ceiling.
41. Ohio: ¾ this times the average of interest rates of special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period.
42. Oregon: Lease payment between related parties are allowed at the lesser of the payments per contract and the owner's cost of the lease.
43. Oregon: A home receives payment up to \$1.09 per patient day for the amount its allowable indirect expenses are less than the indirect ceiling.

44. Oregon: Annualized rate of 10% on average owner's equity.
45. Pennsylvania: Reimbursement for lease payments may not exceed the actual costs of ownership.
46. Pennsylvania: Costs less than ceiling up to a maximum. Proprietary - SNF \$2.57, ICF \$2.16; Nonprofit - SNF \$1.81, ICF \$1.52; 8-½ of statewide average cost projection, 6% of nonprofits.
47. Rhode Island: Not to exceed costs of actual ownership, i.e. interest + depreciation - R.E. taxes, etc.
48. Rhode Island: Limited to leasehold improvements depreciable over the useful life of the asset.
49. Rhode Island: All providers, proprietary and non-profit are allowed a \$0.60 per patient day participation incentive provided that the rate cosigned remains below the aggregate maximum.
50. South Carolina: No more than allowed if facility were to be sold.
51. South Carolina: half the difference to maximum of 7.5% of standard.
52. Tennessee: Up to 1.50 per day (see Reg., p. 65.031 of Attachment 1).
53. Utah: The cost of the owner allowable cost and the costs recognized in the March 1981 rate.
54. Utah: ROE is set on the 3/27/81 rates and does not change as a result of new calculations.
55. Virginia: The same as if the facility was sold.
56. Virginia: Related to patient care.
57. Washington: Lease expense is tested against a lid computed from a regression comparing all contractors' depreciation and interest expense to facility age and contractor types.
58. West Virginia: Lease expense is tested against a lid computed from a regression comparing all contractors depreciation, an interest expense to facility age and contractor types.
59. Wisconsin: Ceiling amount based on year of facility construction and year taken over by an operator. Ceiling is standard estimated ownership cost, new leased structures limited to owner's cost.
60. Wisconsin: No, with select exceptions for remodeling and property taxes.
61. Wisconsin: Percent of difference between "targeted cost" and facility's actual cost.
62. Wisconsin: 1.25 x 3 years composite average cost of Hospital Insurance Trust Fund.

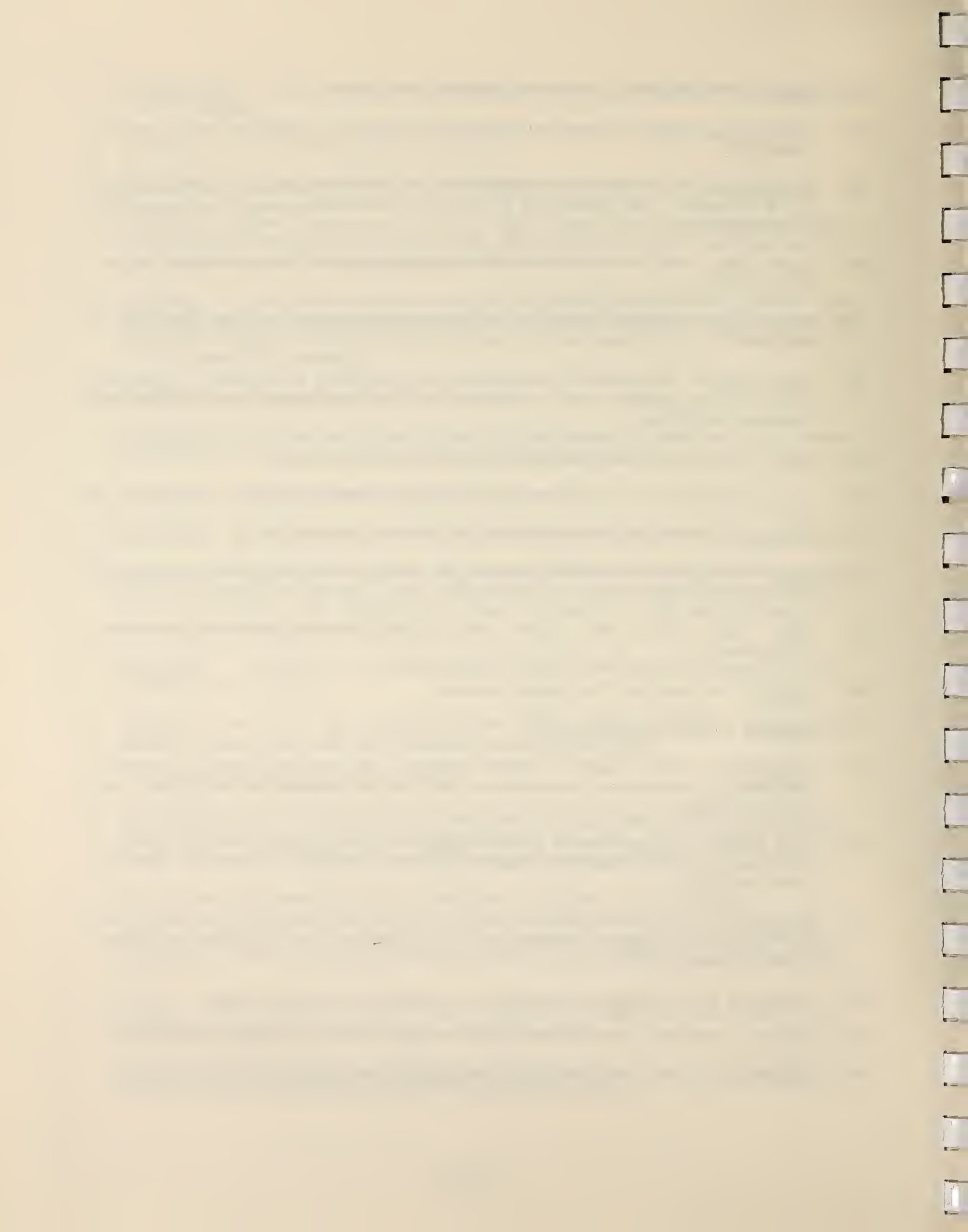


CHART 5
INDEXING INFLATION

	Index Used to Inflate Rates			Index Used to Inflate Rates for Individual Homes			Index Sets Limit for Allowable Costs	Pass Throughs on Certain Costs	Index Applied Uniformly Across Homes	Index Weighted by Each Home	Index Weighted From Groups of Homes	Adjustments are Made in the Index	Adjustments are Made	
	Index Used to Inflate Rates	Industry Wide Rate	Homes	Homes	Other								During the Year	At the Year's End
AL	Yes	Yes						(1)	Yes				Yes(2)	AL
AK														AK
AZ														AZ
AR	Yes	Yes					Yes		Yes			Yes		AR
CA														CA
CO	Yes			Yes					Yes					CO
CT	Yes	Yes			Yes(4)		Yes	Yes(5)	Yes			Yes(3)		CT
DE	Yes						Yes		Yes			Yes		DE
DC	Yes			Yes					Yes					DC
FL	Yes			Yes			Yes		Yes					FL
GA	Yes	Yes					Yes(7)		Yes					GA
HI							Yes		Yes					HI
ID	Yes						Yes	Yes(8)		Yes				ID
IL	Yes			Yes	Yes(9)			Yes(10)						IL
IN									Yes					IN
IA	Yes				Yes(CPI)		Yes		Yes				Yes	IA
KS	Yes	Yes					Yes						Yes(11)	KS
KY	Yes			Yes			Yes		Yes				Yes(12)	KY
LA														LA
ME	Yes			Yes	Yes(13)		Yes	Yes(14)	Yes					ME
MD							Yes		Yes					MD
MA	(15)													MA
MI	Yes	Yes					Yes(16)		Yes					MI
MN							Yes	Yes(17)			Yes	(18)		MN
MS					Yes(19)				Yes					MS
MO														MO
MT														MT
NE									Yes					NE
NV														NV
NH														NH
NJ	Yes			Yes					Yes			Yes		NJ
NM														NM
NY	Yes	Yes					Yes	Yes(21)					Yes	NY
NC	Yes	Yes(22)							Yes					NC
ND	Yes				Yes(23)		Yes							ND
OH	Yes							Yes(24)	Yes					OH
OK	Yes	Yes							Yes					OK
OR	Yes	Yes					Yes		Yes				Yes(25)	OR
PA	Yes						Yes		Yes					PA
RI	Yes			Yes			Yes		Yes					RI
SC	Yes				(26)			Yes	Yes					SC
SD	Yes			Yes					Yes					SD
TN	Yes(27)			Yes			Yes	Yes						TN
TX							Yes		Yes				Yes	TX
UT	Yes				Yes(29)		Yes					Yes(28)		UT
VT									Yes					VT
VA	Yes			Yes			Yes	Yes(30)	Yes					VA
WA														WA
WV	Yes													WV
WI	Yes(31)	Yes			Yes(31)			Yes(32)	Yes					WI
WY	Yes						Yes	Yes(33)						WY

Chapter 1: Introduction to Mathematics

1.1 The Language of Mathematics

1.2 The History of Mathematics

1.3 The Role of Mathematics in Society

1.4 The Nature of Mathematical Proof

1.5 The Importance of Mathematical Thinking

Chapter 2: Set Theory and Logic

2.1 Sets and Set Operations

2.2 Logical Statements and Truth Tables

2.3 Propositional Logic

2.4 Predicate Logic

2.5 Mathematical Induction

2.6 The Axiomatic Method

2.7 The Limits of Formalization

2.8 The Philosophy of Mathematics

CHART 5 FOOTNOTES
INDEXING INFLATION

1. Alabama: Index is not used to limit costs, but to inflate for prospective rate purposes. Property costs such as rent, amortization, interest, and depreciation are not inflated but enter rate as is.
2. Alabama: Established each October 1 for the current fiscal year (7-1/6-30). Rates run from July 1 - June 30. Rates are reset during Sept.-Nov. each year, then weighted back to July 1.
3. Colorado: July 1 and January 1.
4. Connecticut: The implicit price deflator of the GNP is utilized.
5. Connecticut: Plant operation and maintenance, employee benefits and administration (except owner's related party salaries). Since a portion of index is estimated if estimate proves to be incorrect by 5% or +, index adjusted can go down.
6. Delaware: The inflation rate is only given to private homes. It is not given to State-owned institutions.
7. Hawaii: Routine costs limit includes SNF market basket index used to account for actual and projected cost increases - 75th % of private homes only.
8. Idaho: Property costs including depreciation, interest, taxes, leases, etc.
9. Illinois: Updated by components of the C.P.I. after adjustments for Illinois experience. See attached details.
10. Illinois: Capital costs such as depreciated interest and property taxes are not inflated by an index.
11. Kansas: Once at the beginning of the limitation period which runs from 10/1 to 9/30 of each year.
12. Kansas: When a new rate is determined from the provider's cost report filed within 90 days after the end of their fiscal year.
13. Maine: D.R.I. Index.
14. Maine: Capital costs only.
15. Massachusetts: Don't use a prospective rate system.
16. Michigan: Used in the calculation of the variable cost 80th percentile which serves as the variable cost limit.
17. Minnesota: (1) 6% salary exception - salary amounts in excess of a 6% increase are passed through; (2) 85% of the first \$2.00 in excess of the maximum limit is passed through.
18. Minnesota: Adjusted annual (calendar year) but the rate of 125% is fixed.

19. Mississippi: Costs per day.
20. Nebraska: Current under retroactive answers. One to proposed plan to start 8/1/82.
21. New York: Utilities ancillaries other than PT, ST, OT and Prescriptive Drugs, Real Estate Taxes.
22. North Carolina: Industrywide for ICF and SNF. Separate index for ICF-Mental Retardation.
23. North Dakota: The consumer price index CPI (all items) is applied to costs, excluding salaries and fringes, the CPI used is the one for the month in which the facilities fiscal year ends.
24. Ohio: All but general and administrative remit respectively.
25. Oregon: During rate usually 7/1 not in '82 because of budget deficit at end of year January 1.
26. South Carolina: Used CPI, contemplated a state index.
27. Tennessee: (see Reg., p. 65.030, Item 12).
28. Texas: Semi-annually on a routine basis.
29. Utah: CPI less mortgage interest.
30. Virginia: Education and plant costs.
31. Wisconsin: Only for calendar year '82. System will revert to referencing actual cost (with appropriate limits in '83). 1982's index was a sliding scale, i.e., expensive homes got smaller increases, low cost homes got bigger increases.
32. Wisconsin: Primarily related to capital, e.g., interest expense is passed through in its entirety.
33. Wyoming: Costs due to change in federal and state law and regulations, eg., minimum wage increase.

CHART 6

Cost Limits										
Homes are Grouped for Rates	Limits Placed on Nursing Home Costs	Limits Placed on Total Costs	Limits on Cost Centers	Different Limits for Different Groups of Homes	Limits on Total Costs Set By:				Other	
					Arbitrary Limit	Percentile Limit	Mean	Mean and Percentage of Mean		
AL	Yes(1)	Yes	Yes(2)			Yes			AL	
AK									AK	
AZ									AZ	
AR	Yes	Yes		Yes(3)		Yes			AR	
CA									CA	
CO	Yes(4)	Yes	Yes(5)			Yes			CO	
CT	Yes(6)	Yes	Yes(7)	Yes(5)		Yes			CT	
DE	Yes(9)	Yes		Yes(8)		Yes			DE	
DC									DC	
FL		Yes				Yes			FL	
GA	Yes(10)	Yes	Yes	Yes					GA	
HI	Yes	Yes	Yes(11)	Yes(12)				Yes(outst. charges)	HI	
ID	Yes	Yes	Yes(13)	Yes					ID	
IL	Yes	Yes	Yes(14)	Yes(15)					IL	
IN	Yes	Yes		Yes(16)	Yes		Yes		IN	
IA		Yes	(see 17)			Yes			IA	
KS	Yes(18)	Yes	Yes(19)	Yes(20)		Yes			KS	
KY		Yes(21)	Yes(19)			Yes		Yes(115% of median)	KY	
LA			Yes(22)						LA	
ME									ME	
MD		Yes				Yes			MD	
MA	Yes	Yes	Yes(23)	Yes(24)			Yes		MA	
MI	Yes(25)	Yes	Yes(26)	Yes(26)		Yes			MI	
MN	Yes	Yes	Yes(27)	Yes(28)				Yes(125%)	MN	
MS	Yes	Yes	Yes(30)			Yes			MS	
MO	Yes	Yes		Yes			Yes		MO	
MT									MT	
NE	Yes	Yes	Yes(31)	Yes(32)		Yes		Yes(110%)	NE	
NV		Yes	Yes(33)						NV	
NH	Yes	Yes	Yes(34)	Yes(35)					NH	
NJ	Yes	Yes	Yes(36)					Yes	NJ	
NM	Yes	Yes	Yes(37)	Yes(38)		Yes			NM	
NY	Yes	Yes	Yes	Yes(39)					NY	
NC	Yes	Yes	Yes(40)			Yes			NC	
ND		Yes	Yes(41)						ND	
OH	Yes	Yes	Yes(42)	Yes				Yes(43)	OH	
OK	Yes	Yes					Yes		OK	
OR		Yes	Yes(44)			Yes			OR	
PA	Yes	Yes	Yes(45)					Yes(46)	PA	
RI	Yes	Yes	Yes(47)					Yes(48)	RI	
SC	Yes	Yes	Yes(49)	Yes(50)					SC	
SD	Yes	Yes	Yes(51)					Yes(52)	SD	
TN		Yes		(53)		Yes			TN	
TX									TX	
UT		Yes	Yes(54)					Yes	UT	
VT		Yes	Yes(prop. costs)					Yes	VT	
VA	Yes	Yes	(55)	Yes(56)				Yes(a median)	VA	
WA		Yes	Yes(57)						WA	
WV		Yes	Yes(58)						WV	
WI		Yes	Yes					Yes(59)	WI	
WY		Yes	Yes			Yes			WY	

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

CHART 6 FOOTNOTES GROUPING OF FACILITIES

1. Alabama: 1) SNF and ICF, Combination Facilities (grouped together) Administrative cost center 60th cap by bed size groupings: 1-50 beds, 51-75 beds, 76-100 beds, 101-150 beds, and 151 beds and up. Overall 60th percentile within facility classification groupings: SNF only, ICF only, combination (ICF-MR facilities are limited by an overall 60th percentile under different reimbursement guidelines.)

2) Administrative 60th% Cap (SNF, ICF, Combination Grouped Together)

	<u>1-50 beds</u>	<u>51-75 beds</u>	<u>76-100 beds</u>	<u>101-150 beds</u>	<u>151 and up</u>
Facilities	38	40	39	57	33
Beds	1605	2551	3414	6671	6179
<u>Overall 60th Cap</u>					
	<u>ICF only</u>	<u>SNF only</u>	<u>Combination only</u>	<u>ICF/MR</u>	
Facilities	18	2	103	5	
Beds	1000	86	19,334	1523	

2. Alabama: General and administrative capped at 60%.
3. Arkansas: Only administrative salaries limited by home size.
4. Colorado: See Regs. 8.441.2.
5. Colorado: See Regs. 8.441.3.
6. Connecticut: By level of care, i.e., SNF, ICF, HFA.
7. Connecticut: As described in IIIC above for laundry, housekeeping, dietary and nursing.
8. Connecticut: Each facility has its own "cap" based on historical costs.
9. Delaware: There are two groupings: private homes and state-owned homes.
10. Georgia: Ch. 1000, page x-3.
11. Hawaii: Per HIM 15-I, Sec. 2500. Limits are placed on inpatient general routine service cost.
12. Hawaii: caps lower for freestanding SNFs than for hospital based SNFs and non-SMSA SNFs than SMSA SNFs; E4-Routine Costs 112% of group mean.
13. Idaho: Non-property, non-ICF/MR patient care costs.
14. Illinois: The general service costs and administrative costs are limited to a ceiling of the 60th percentile of the group costs. Nursing costs and capital costs also have ceiling limits built into the reimbursement methodology.

15. Illinois: The caps are based upon the costs incurred by the homes in that group, e.g., the support costs are limited to both percentile.
16. Indiana: Each market area has a different cap.
17. Iowa: Individual items such as administrators salaries, owner/operator/related party conditions.
18. Kansas: SNC, ICF, and ICF/MR.
19. Kansas: Administration, Property, Room and Board, and Healthcare.
20. Kansas: Limits established for each level of care, i.e., SNF, ICF or ICF/MR.
21. Kentucky: Only on newly participating facilities.
22. Kentucky: Nursing, dietary, property, all other costs.
23. Massachusetts: The cost centers are variable, and nursing costs and costs which are over 1 standard deviation above the mean are not allowed.
24. Massachusetts: The mean costs are different.
25. Michigan: Facilities are grouped into four classes:

	<u>Facilities</u>	<u>Beds</u>
1. Privately owned proprietary and non-profit nursing homes (Both ICF & SNF)	372	39,801
2. County owned medical care facilities and hospital LTC units (Both ICF & SNF)	64	6,417
3. Privately owned SNF/MR facilities	9	1,005
4. State owned ICF/MR Institutions	12	4,328
26. Michigan: Plant cost (interest, depreciation, lease, rental and property taxes) limit same for classes 1 to 3 above. Variable cost (total cost less plant cost) limit is different 80th percentile for each class 1 to 3 above. ICF/MRs (4th class above) are paid in accordance with Medicare Principles of Reimbursement.
27. Minnesota: Nursing care, general and administrative, top management compensation, property costs.
28. Minnesota: Treated different depending upon whether profit/nonprofit.
29. Mississippi: To extent minimum occupancy or 80% is met.
30. Mississippi: Owner's compensation, home office administrative costs, number and type of vehicles.
31. Nebraska: 14% of variable cost.
32. Nebraska: Overall set at cap. for their group as described in Chart IV, #30.
33. Nevada: Administration and housekeeping.
34. New Hampshire: Percentile limit placed on total allowable variable costs.

35. New Hampshire: Percentile is calculated for each of 3 bed size groups described below:
- | | | |
|------------|-----------------|-------------|
| 0-49 beds | - 22 facilities | - 892 beds |
| 50-99 beds | - 26 facilities | - 1835 beds |
| 100+ beds | - 19 facilities | - 3097 beds |
36. New Jersey: Food, non-food general services, administration, legal fees, building square footage and cost per square foot, land area and value of area, nursing utilities, insurance, special patients care services, maintenance, original equipment.
37. New Mexico: Administrator's compensation.
38. New Mexico: Separate limits calculated for ICF, SNF, and ICF/MR.
39. New York: Geographic region and bed size.
40. North Carolina: Limits are placed on groups of cost centers. A direct group and indirect group. We limit reimbursement for some items such as the Medical Director.
41. North Dakota: Administrative costs are limited to 15% of total costs.
42. Ohio: Limits on raw food, dietary support, medical support, nursing and rehabilitation; physician review, general and administrative; cost of ownership; physicians' review – total costs limited by costs charges or Medicare rate.
43. Ohio: Lower of cost or charges and/or Medicare rate are only limits to total rate.
44. Oregon: Indirect cost centers of administrative salaries, general and administrative expenses and plant and shelter expenses.
45. Pensylvania: Nursing costs, administrative and general costs are limited.
46. Pennsylvania: Use the median to set limits to net operating costs as they apply to each SMSA group.
47. Rhode Island: Fixed property 90th percentile. Other property 70th, nursing and dietary 80th, Energy 90th, all other 70th.
48. Rhode Island: The sum of the cost centers subject to the maximum in each cost center.
49. South Carolina: Nursing, dietary, housekeeping, laundry and maintenance and administrative.
50. South Carolina: Based on type and size of facility.
51. South Dakota: Direct patient care, direct administration.
52. South Dakota: 110%.
53. Tennessee:
 ICF 30.61 - Methodology is same as outlined in state plan.
 SNF 46.36 - Methodology is same as outlined in state plan.
 ICF/MR - None

54. Texas: Reimbursement rates for 3 levels of care are set at the sum of the 60th percentile per diem projected expenses in patient care, facility and administrative costs areas.
55. Virginia: Items, administrators compensation, directors' fees, medical directors' fees.
56. Virginia: The calculation costs for different groups promotes a different median which represents the cap.
57. Washington: Administration (percentile limit) and food (limit set by mean).
58. West Virginia: Administration and Food.
59. Wisconsin: Sliding scale increases within range of 5%-7%. Expensive homes get lower increase, lower cost homes set higher increase.

CHART 7
COST LIMITS

Cost Limits							Considering New System	
Limits on Cost Center Set By				Other	Costs Exempted From Limits	Case Mix Adjustment		
Arbitrary Limit	Percentile Limit	Mean	Mean and Percentage of Mean					
AL	Yes						AL	
AK							AK	
AZ							AZ	
AR							AR	
CA	Yes	Yes			Yes(1)		CA	
CO						Yes(2)	Yes(3)	CO
CT					Yes			CT
DE					(4)			DE
DC							DC	
FL	Yes(5)			Yes(6)	Yes	Yes	FL	
GA			Yes		Yes(8)	(7)	GA	
HI		Yes			Yes(9)		HI	
ID		Yes					ID	
IL							IL	
IN						Yes	IN	
IA	Yes				(10)		IA	
KS								KS
KY					Yes(11)			KY
LA								LA
ME							ME	
MD					Yes(12)		MD	
MA	Yes	Yes					MA	
MI					Yes(13)	Yes(14)		MI
MN					Yes(15)			MN
MS					Yes(16)			MS
MO						Yes	MO	
MT							MT	
NE	Yes	Yes			Yes(17)		NE	
NV						Yes(18)		NV
NH			Yes			Yes(19)	Yes(20)	NH
NJ					Yes			NJ
NM			Yes				NM	
NY						Yes	NY	
NC	Yes			Yes(21)			NC	
ND								ND
OH				Yes(22)	Yes(23)	Yes(24)	Yes	OH
OK								OK
OR		Yes					OR	
PA	Yes	Yes		Yes(25)	Yes(26)		PA	
RI	Yes(27)						RI	
SC				Yes(28)	Yes(29)	Yes	SC	
SD			Yes(30)				SD	
TN					Yes(31)		TN	
TX							TX	
UT	Yes			Yes(32)		Yes(33)	UT	
VT							VT	
VA							VA	
WA	Yes	Yes	Yes				WA	
WV	Yes	Yes(food)					WV	
WI	Yes				Yes	Yes	WI	
WY							WY	

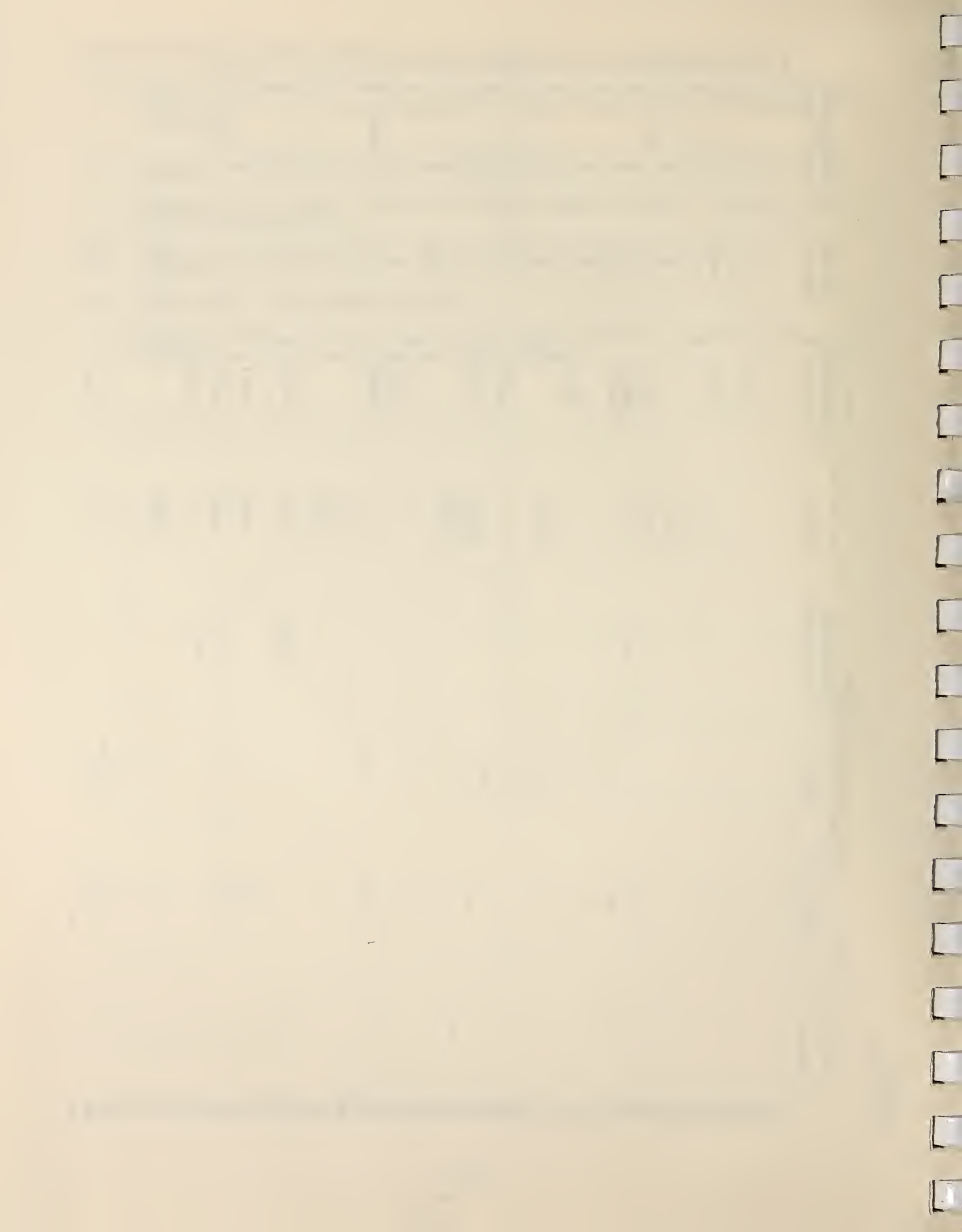


CHART 7 FOOTNOTES
COST LIMITS

1. Arizona: All reimbursed except travel and administrative salary.
2. Colorado: See Regs. 8.4413.
3. Colorado: See Regs. HB1288.
4. District of Columbia: SNF care can't be more than 2.4 hrs care per patient per day, and ICF can't exceed 2.0 hours ppd.
5. Georgia: 75th % routine and specialty services, dietary, laundry, housekeeping, administrative, property 90th %, insurance 100th.
6. Georgia: Insurance and property tax not limited.
7. Georgia: Huskins, Sells,... is preparing a flat rate method for property reimbursement. This is to be based on an age and square footage, using the fair rental value.
8. Hawaii: Allocated capital-related costs that are part of general inpatient routine service costs are excluded from the routine cost limitation. (Per HIM-15-II Sec. 334.1).
9. Idaho: Property costs.
10. Iowa: Most cost items not limited.
11. Kentucky: Nursing 125% of median, property 105% of median, dietary 125% of median; all other costs 105% of median.
12. Maryland: Any cost that is an allowable and reasonable cost is included, but the aggregate costs of a facility are limited to a total cost/day.
13. Michigan: Plant cost limit on plant costs; see Chart 6, #26.
14. Michigan: Ancillary service cost centers--physical and occupational therapies and speech and audiology.
15. Minnesota: Cost indices--construction cost index used to determine the investment per limitation for allowable depreciation purposes.
16. Mississippi: Maximum number amt. or percent of other costs.
17. Nebraska: Under current-fixed costs.
18. Nevada: Employee benefits and health care.
19. New Hampshire: No limit on fixed costs or real estate taxes.
20. New Hampshire: Considering changes in particular cost reimbursement issue, however, changes are informative stages and no written discussions or proposed documents are available at this time.

21. North Carolina: Analysis and comparison using surveys and cost report experience. It is an informal process.
22. Ohio: E4 - 115% mean for dietary, medical supplies, nursing supplies.
23. Ohio: General and administrative expenses mean + 4/5 SD.
24. Ohio: F - utilities, property, taxes, payroll taxes.
25. Pennsylvania: Variety of percentile and absolute limits by cost center general and administrative costs are capped at 13% of total operational costs with some exception allowed.
26. Pennsylvania: Any cost items not specifically limited are still limited by the net operating ceiling.
27. Rhode Island: Fixed property 90th percentile. Other property 70th, nursing and dietary 80th, Energy 90th, all others 70th.
28. South Carolina: Nursing, dieting, housekeeping, laundry and maintenance and administrative. E5 - lower of mean or actual costs.
29. South Carolina: Utilities, cost of capital, taxes and insurance and medical supplies.
30. South Dakota: 110% of statewide class: direct patient care, dietary, laundry, administrative, net per diem.
31. Tennessee: Only limits is owner's compensation, return on equity, containment incentive and the inflation factor.
32. Utah: The 3/27/81 property costs allowed is that rate.
33. Utah: See section 700 of attached 419-D: SNF, IMR-1, IMR-3, ICF, IMR-2.

CHART 8
HOSPITAL REIMBURSEMENT: SPECIAL ISSUES

Special Exceptions for High Volume Medicaid Hospital		Special Exceptions for High Volume Medicaid Hospital Definition of Provider		Adjustments		Non-Medicare Regs for Hospital Based Physicians		Alternative Reimbursement Systems		Considering Alternative Reimbursement	
AL	Yes(1)										
AK								Yes			AL
AZ											AK
AR											AZ
CA											AR
CO											CA
CT											CO
DE											CT
DC											DE
FL								Yes		Yes	DC
GA											FL
HI								Yes			GA
ID											HI
IL	Yes	(4)		(5)				Yes			ID
IN											IL
IA											IN
KS										Yes	IA
KY	Yes	(6)		(7)							KS
LA											IA
ME						Yes		Yes			KS
MD											KY
MA	Yes	(8)		(9)				Yes			LA
MI	Yes(11)			(12)		(13)		Yes		Yes(10) (15) Yes	ME
MN											MD
MS											MA
MO											MI
MT											MN
NE						(16)		(16)			MS
NV											MO
NH								(17)		(change 7/1/82)	MT
NJ											NE
NM											NV
NY											NH
NC		(18)						Yes			NJ
ND											NM
OH											NY
OK						Yes					NC
OR											ND
PA	Yes										OH
RI								Yes			OK
SC											OR
SD											PA
TN						Yes(19)					RI
TX								Yes(20) (21)			SC
UT											SD
VT											TN
VA	Yes	(22)		(23)							TX
WA	Yes	(24)		(25)							UT
WV	Yes	(28)		(29)		(26)		(27)			VT
WI	Yes					(30)		(31)			VA
WY											WA
											WV
											WI
											WY

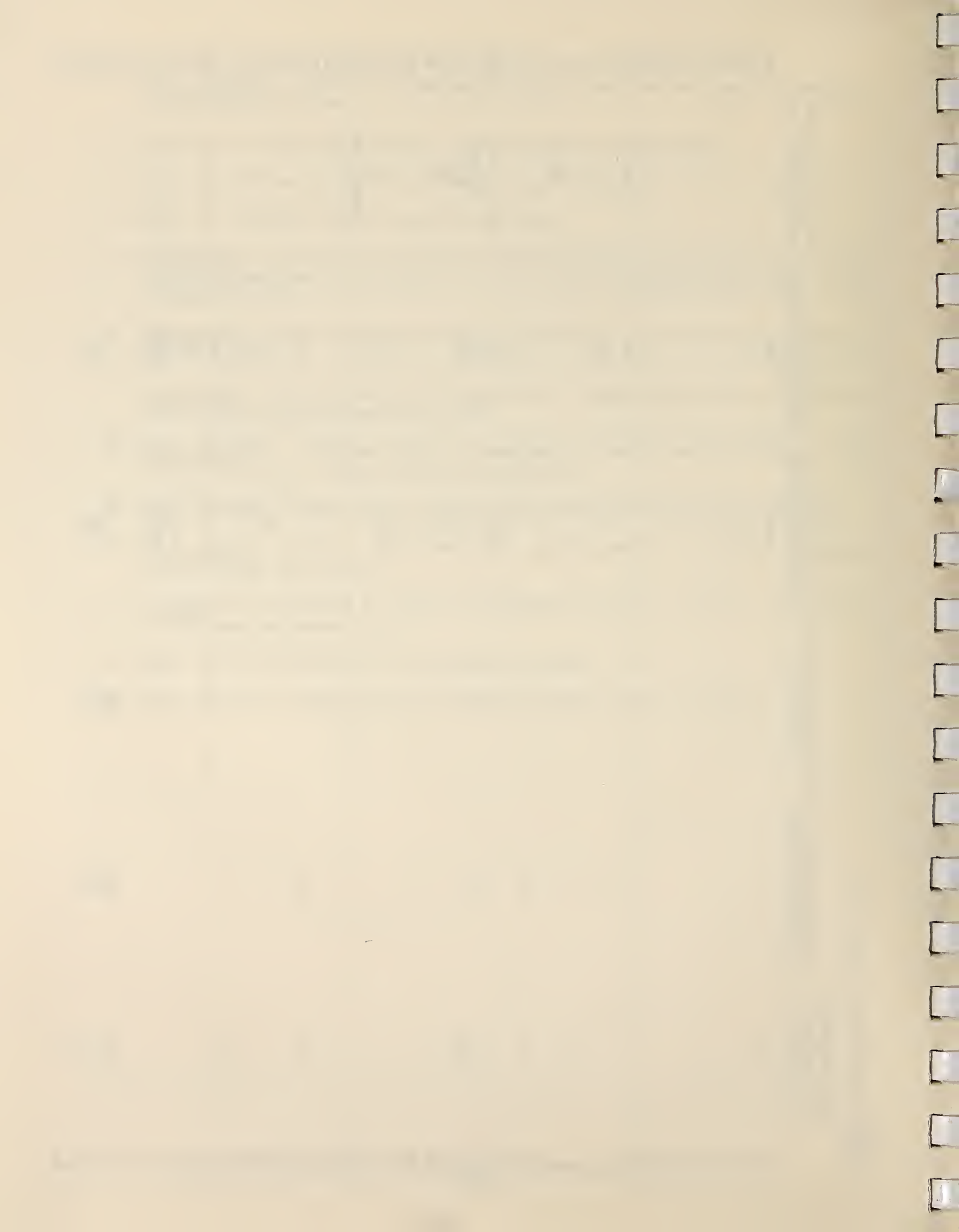


CHART 8 FOOTNOTES
HOSPITAL REIMBURSEMENT: SPECIAL ISSUES

1. Alabama: Refer to Alabama Medicaid Regulations, Ch. 23, Subchapter C, part 13, pgs 5 and 5.1.
2. Alabama: Refer to AL, Med REg. Ch. 23, Subchapter G, part I, pgs 6 and 7.
3. Arkansas: Reimbursements compensated for in the calculation of hospital per diem rate.
4. Illinois: Hospitals with at least 65% of their inpatient days reimbursed under Medicare, Medicaid, GA and AMI and at least 35% of their inpatient days are reimbursed by Medicaid or alternatively, at least 35% of the inpatient days are reimbursed by Medicaid.
5. Illinois: A special pool is established to increase the payment rate to these facilities which have demonstrated a severe cash flow problem.
6. Kentucky: 20% or more of total occupancy must be Medicaid.
7. Kentucky: Maximum rate set at 120% of median.
8. Massachusetts: For chronic hospitals only, relief begins when 16% or more of patients served by hospital are publicly aided, free care or bad debt.
9. Massachusetts: Per diem rate for inappropriately placed patients adjusted upwards, depending on hospital's percentage of low-income patients and hospital's conformity with discharge planning guidelines.
10. Massachusetts: We plan to extend methodology to acute hospitals. We may also be moving toward totally different full-payor prospective maximum allowable cost system, pending action of state legislature and HCFA.
11. Michigan: 24% or more Medicaid volume.
12. Michigan: A high volume Medicaid hospital is allowed a one percent increase in the ppd limitation for each \$ Medicaid patient days exceeds 25% of total patient days.
13. Michigan: HBPs costs are added into "included" and "operating" costs and are limited by indices and percentiles of ppd costs.
14. Michigan: See approved state plan 1/1/82.
15. Michigan: See proposed state plan 7/1/82.
16. Nebraska: Change in hospital reimbursement method from retrospective to prospective to be implemented FY '82-'83. Hospital outpatient select codes also effective in FY '82-83. All material still considered in draft form.
17. New Hampshire: Is using a variant of Medicare's reasonable cost reimbursement method.

18. North Carolina: During the past year, we granted rate and increases to hospitals that had a combined Medicaid-Medicare case load of 65% or greater or a Medicaid case load of 40%.
19. Texas: Texas Medicaid Program applies Medicare regulations for reimbursement of hospital based physicians. Regulations can be found in Medicare Provider Reimbursement Manual (HIM-15-1), Chapter 21, Costs Related to Patient Care, Sec. 2108, Provider Based Physician Services, p. 21-5.
20. Texas: Under Texas Medicaid Program ambulance services are reimbursed according to Medicare's reasonable charge methodology.
21. Utah: Inpatient is the same as Medicare.
22. Virginia: In excess of 8% Medicaid utilization.
23. Virginia: Those providers receive a 1% adjustment in their ceiling for each % the utilization exceeds 8%.
24. Washington: A hospital whose Medical Assistance admissions are equal to or higher than 25 percent of their total admissions.
25. Washington: The Wage Component Limitaiton, as described in item III of this section of the questionnaire, is not aplpied to hospitals servinga disproportionate number of low-income patients with special needs, as defined.
26. Washington: No. However, as a matter of long-standing policy, hospital based emergency room physician services may not be combined-billed with the hospital charges to the Medical Assistance program.
27. Washington: Regulation (WAC 388-87-070) was filed for emergency adoption on July 21, 1982. The formal review process is currently under way, with the target date for permanent adoption of Augsut 25, 1982.
28. West Virginia: A hospital whose medical assistance admissions are equa to or higher than 25% of their total admissions.
29. West Virginia: The wage component limitation is not applied to hospitals serving a disproportionate number of low-income patients with special needs.
30. West Virginia: No, hospital based emergency room physician services may not be combined-billed with the hospital charges to medical assistance programs.
31. West Virginia: Regulations (WAC 388-87-070) filed under emergency adoption on July 21, 1982. Formal review process underway. Target date for permanent adoption August 25, 1982.

Nursing Home Reimbursement

Questionnaire

I. Capital Reimbursement

A. For the purpose of capital reimbursement, is the value of the home recognized by the state set according to:

1. Historic costs: **Yes.** **No.** If yes, are the historic costs set from:

a. date of construction: **Yes.** **No.**

b. date of last sale: **Yes.** **No.**

c. other: **Yes.** **No.** If yes, please describe:

2. Replacement costs: **Yes.** **No.** If yes, please describe:

3. Market value: **Yes.** **No.** If yes:

a. Must the buyer and seller be "unrelated?" **Yes.** **No.** If yes, please give the definition of "unrelated:"

b. Are there dollar limits placed on market transactions? **Yes.** **No.** If yes, please describe:

4. Other: **Yes.** **No.** If yes, please describe:

B. Does the state place a dollar maximum on the value of a bed? **Yes.** **No.** If yes, please describe what the maximum is and how it is set:

C. Is depreciation permitted? **Yes.** **No.** If yes,

1. Is depreciation straightline? **Yes.** **No.**

2. Is accelerated depreciation permitted? **Yes.** **No.** If yes, please describe what kind of accelerated depreciation is permitted:

D. Is the home required to fund depreciation payments? **Yes.** **No.**

1. If yes, please describe:

2. If no, does the state fund depreciation for the home? **Yes. No.** If yes, please describe:

E. Is the useful life of a facility:

1. 30 years. **Yes. No.**
2. 35 years. **Yes. No.**
3. 40 years. **Yes. No.**
4. Other. **Yes. No.** If yes, please describe:

F. Are interest expenses recognized? **Yes. No.** If yes,

1. does the state establish the interest rate it will recognize for reimbursement: **Yes. No.** If yes,
 - a. Please describe how the rate is set:

- b. Is a flat rate imputed to all homes? **Yes. No.** If yes, what is that rate:

2. Are the actual interest expenses incurred by a home reimbursed? **Yes. No.** If yes, are those reimbursable rates set according to:

- a. Prevailing rates? **Yes. No.** If yes, please describe how prevailing rates are determined:

- b. Prevailing rate to a ceiling? **Yes. No.** If yes, please describe how the ceiling is determined:

- c. The Medicare Rate of Return? **Yes. No.**

- d. Other? **Yes. No.** If yes, please describe:

- G. If the home has negative net equity (i.e., debts in excess of the book value of the home and land), does the state reimburse the home interest expenses attributed to the negative net equity? **Yes. No.**

1. If yes, are:

- a. All interest expenses reimbursed? **Yes. No.**

- b. Interest expenses to a ceiling? **Yes. No.** If yes, please describe what the ceiling is and how it is set:

2. Are homes penalized for the negative net equity interest expenses incurred? **Yes. No.** If yes, please describe:

H. Is the sale of a home recognized for reimbursement? **Yes. No.**

1. If yes, is the value of the home established according to:

a. Depreciated replacement costs? **Yes. No.** If yes, please describe:

b. Income value? **Yes. No.** If yes, please describe:

c. Assessed value? **Yes. No.** If yes, please describe:

d. Market value? **Yes. No.** If yes, please describe:

e. Other? **Yes. No.** If yes, please describe:

2. If a sale occurs, is there a depreciation recapture provision? **Yes. No.** If yes, please describe:

3. Are there reimbursement incentives for an owner not to sell his home? **Yes. No.** If yes, please describe:

I. Are lease payments reimbursed? **Yes. No.**

1. If no, please describe how operators of leased facilities are reimbursed:

2. If yes, (i.e. the state reimburses lease payments) does:

a. the state set a ceiling on lease payments? **Yes. No.** If yes, please describe what that ceiling is and how it is determined:

b. the state require that the leases be of a minimum duration (e.g. at least 3 years)? **Yes. No.** If yes, what is that minimum:

3. Are leasehold rights a reimbursable cost (i.e. reimbursement of leasehold rights would entail reimbursing the owner of a lease in addition to reimbursing the lease payments made by the operator leasing the home)? **Yes. No.** If yes, please describe any limits placed on that reimbursement:

J. Have changes in federal tax laws resulted in:

1. A reduction of the useful life of a facility to 15 years? **Yes. No.**
2. Adoption of accelerated depreciation? **Yes. No.**
3. Other changes? **Yes. No.** If yes, please describe:

II. Profits and Return on Equity

A. Is there an explicit profit component in the reimbursement system? **Yes. No.**
If yes, are profits determined on a:

1. Fixed fee per patient day: **Yes. No.** If yes, please describe what the fee is and how it is determined:
2. Variable fee per patient day up to a maximum? **Yes. No.** This is often referred to as an "efficiency incentive." It may equal an absolute dollar amount (e.g. a home may receive up to \$1.00 per patient day if its costs are at or below \$34.00 per day, \$.99 to \$.01 if costs are between \$34.01 and \$34.99 a day and no payment if costs are \$35.00 or greater) or a percent of the difference between a targeted cost per day and an actual lower costs. If yes, please describe what the fee is and how it is determined:

B. Is a return on equity paid? **Yes. No.** If yes,

1. Is the capital base used for equity computations different from the one described in section I.A.? **Yes. No.** If yes, please describe:
2. Is the rate of return:
 - a. The Medicare rate of return. **Yes. No.**
 - b. Other? **Yes. No.** If yes, please describe:

III. Indexing Inflation: Prospective Rate/Cost Ceiling Determination.

A. Is an index used to inflate nursing home rates (price paid regardless of costs incurred by any one facility) each year? **Yes. No.** If yes, is the index used to inflate:

1. An industrywide rate? **Yes. No.**
2. Rates for groups of homes? **Yes. No.**
3. Rates for individual facilities? **Yes. No.**
4. Other? **Yes. No.** If yes, please describe:

- B. Is an index used to set a maximum limit on allowable costs? **Yes.** **No.**
- C. Please describe how the index is constructed:
- D. Does the index allow for a pass-through on certain costs, i.e., are increases in certain costs unrestrained by the index and incorporated in their entirety into the rates? **Yes.** **No.** If yes, please describe those costs:
- E. Once the index is derived, is it:
1. Applied uniformly across homes (i.e., is the same rate of increase applied to all homes)? **Yes.** **No.**
 2. If no, does the different application of the index result from:
 - a. weighing the index to reflect the specific cost components of each home? **Yes.** **No.** If yes, please describe:
 - b. weighing the average distribution of cost components within groups of homes? **Yes.** **No.** If yes, please describe:
 - c. Other? **Yes.** **No.** If yes, please describe:
- F. Are adjustments made in the index? **Yes.** **No.** If yes, are the adjustments made:
1. During the rate year. **Yes.** **No.** If yes, please indicate how frequently they are made:
 2. At the end of the rate year. **Yes.** **No.** If yes, please indicate how many months after the end of the rate:
- G. Once the index is adjusted, please indicate how it affects the revenues received by the homes.

IV. Groupings

- A. Do you group facilities for rate or cost ceiling determination? **Yes.** **No.**
1. If yes, please describe those groupings in detail:

2. Please indicate the total number of facilities and beds within each category.

V. Cost Limits

A. Do you place limits on any nursing home costs? **Yes.** **No.**

B. If yes, are limits placed on:

1. Total costs? **Yes.** **No.**
2. Cost centers? **Yes.** **No.** If yes, please indicate which centers:

C. Are the caps for a home in different groups different? **Yes.** **No.** If yes, please describe:

D. Are the limits for total costs set by:

1. An arbitrary limit? **Yes.** **No.**
2. A percentile limit? **Yes.** **No.**
3. The mean? **Yes.** **No.**
4. The mean and percentage of the mean? **Yes.** **No.** If yes, what percentage?
5. Other? **Yes.** **No.** If yes, please describe:

E. How are limits set for cost centers?

1. Arbitrary limits. **Yes.** **No.**
2. Percentile limit. **Yes.** **No.**
3. Mean. **Yes.** **No.**
4. The mean and percentage of the mean. **Yes.** **No.** What percentage?
5. Other. **Yes.** **No.**

F. Are there cost items which are reimbursed and which are not limited? **Yes.** **No.** If yes, please describe:

VI. Exceptions Process

A. What are the criteria for appealing for an exception to a reimbursement rate?

B. What state agency hears those appeals?

- C. How many institutions applied for an exception in the most recent rate year?
- D. How many were granted an exception in the most recent rate year?
- E. What was the dollar amount of the exceptions granted?

VII. Case Mix Adjustment

Is the nursing home reimbursement system adjusted for case mix? **Yes. No.**
Please submit the regulations describing that process and any evaluations you have recently performed on that case-mix adjustments.

VIII. If you are considering changing your nursing home reimbursement method, please enclose any discussion papers or proposed regulations. Please mark "proposed" on these documents.

Hospital Reimbursement: Special Issues

- I. Does your Medicaid program have regulations governing a special exceptions process for hospitals with a high volume of Medicaid and/or other indigent patients?
 - A. What is the definition of high volume provider?
 - B. Please describe the special process of adjustments made for these providers.
 - II. Do you have specific regulations governing the reimbursement of hospital based physicians? If yes, please enclose those regulations.
 - III. If you are reimbursing hospitals according to any method other than Medicare's reasonable cost reimbursement method, please enclose the regulations governing that alternative methodology.
 - IV. If you are considering changing your hospital reimbursement method, please enclose any discussion papers or proposed regulations. Please mark "proposed" on these documents.
-

APPENDIX C

NURSING HOME REIMBURSEMENT RATES

The following tables present data on Medicaid nursing home reimbursement levels in Fiscal Years 1979, 1980 and 1981. Table C-1 gives reimbursement rates for skilled nursing facilities (SNF), Table C-2 for intermediate care facilities (ICF), and Table C-3 for intermediate care facilities for the mentally retarded (ICF-MR). The average rate per patient day gives the average total per diem payment rate, including payments from patients, paid to nursing facilities for the care of Medicaid recipients. While the basic services required of nursing homes under federal standards of participation are included in this rate in all states, there is substantial variation regarding payment policy for ancillary services. The right hand side of the tables indicate whether physical therapy, occupational therapy, non-legend drugs, prescribed drugs, medical supplies, durable equipment or other ancillary services are included in the per diem rate. The final column of these tables rank orders the states by their FY81 average payment rates per patient day. These rankings should be interpreted with caution, however, as individual state rates are not directly comparable in that they may each cover different sets of ancillary services.

The reimbursement methodologies described in preceding tables, and in the text, determine the total rate of payment, while recipient eligibility policies and the economic status of individuals served by the program determine how much is paid by Medicaid and how much by the recipient. The average Medicaid payment per patient day indicated on the tables gives the dollar amount paid by the Medicaid program only, exclusive of direct payments from the patients and from other sources.

The data in Tables C-1, C-2, and C-3 was provided to NGA's State Medicaid Information Center by state Medicaid officials in the spring of 1982. NGA developed the

survey questionnaire and conducted the survey at the request of the Office of Research and Demonstration, Health Care Financing Administration. A number of individuals contributed to the construction of that survey, including John Holohan of the Urban Institute. Norm Charles of the Michigan Medicaid program was principally responsible for the design of the survey instrument. Without Mr. Charles' concerted effort and exceptional working knowledge of the issues involved, the survey could not possibly have been completed in the very short time frame available at that time.

The information from the survey was shared with the La Jolla Management Corporation which verified it and reproduced it in its document, Medicaid Program Characteristics. This rate information will also be included in the NGA State Medicaid Information Center's Catalogue of State Medicaid Program Changes and will be updated periodically.

TABLE C

SNF REIMBURSEMENT RATES

TABLE C-1
SNF REIMBURSEMENT RATES

	MEDICAID USE, EXPENDITURE, AND RATE DATA						ANCILLARY SERVICES INCLUDED IN PER DIEM RATE							State Rank by Average Rate (FY81)			
	AVERAGE RATE PER PATIENT DAY (\$)		PERCENTAGE OF MEDICAID PAYMENT PER PATIENT DAY (%)		TOTAL DAYS OF CARE (in thousands)												
	FY79	FY80	FY81	FY79	FY80	FY81	FY79	FY80	FY81	PT	OT	Non-Legend Drugs	Prescribed Drugs		Medical Supplies	Durable Equipment	Other
ALABAMA	26.95	29.33	38.79	MM	MM	MM	MM	MM	MM	MM	X	-	X	X	X	X	38
ALASKA 1/	84.97	93.45	97.39	MM	MM	MM	1	2,416	2,485	2,568	X	X	X	X	X	-	1
ARKANSAS	20.97	23.35	25.53	MM	MM	MM	16.52	17.89	18.81	MM	-	-	-	-	-	-	46
CALIFORNIA	30.44	35.27	36.30	MM	MM	MM	24.10	27.34	27.82	23,854	X	X	-	X	X	X	30
COLORADO	23.14	26.83	28.73	MM	MM	MM	17.00	19.13	21.11	1,179	X	-	X	-	-	-	42
CONNECTICUT	33.63	37.11	41.49	MM	MM	MM	27.16	29.63	32.73	4,884	X	X	-	X	X	X	16
DELAWARE	52.30	54.31	44.28	MM	MM	MM	44.51	45.28	45.76	13	-	X	X	X	X	-	12
DIST COLUMBIA	32.38	66.93	65.98	MM	MM	MM	45.78	59.59	57.76	34	X	X	X	X	X	-	5
FLORIDA	28.19	31.29	MM	MM	MM	MM	21.52	23.83	26.21	2,562	X	X	X	X	X	-	43
GEORGIA	23.38	25.93	28.63	MM	MM	MM	18.20	20.40	22.21	3,145	X	X	X	X	X	X	MM
HAWAII	75.04	62.11	71.56	MM	MM	MM	48.97	55.03	62.95	402	-	-	-	-	-	-	2
IDAH0 2/	26.82	29.73	33.12	MM	MM	MM	22.75	27.09	32.25	333	X	X	X	X	X	X	36
ILLINOIS	26.02	28.82	32.60	MM	MM	MM	20.43	22.49	23.99	3,954	MM	MM	MM	MM	MM	MM	37
INDIANA	22.75	25.56	35.62	MM	MM	MM	28.05	32.06	43.51	27	-	-	-	-	-	-	X
IOWA	23.83	25.48	27.80	MM	MM	MM	19.66	20.15	21.65	116	X	X	-	-	-	-	32
KANSAS	37.50	41.25	42.74	MM	MM	MM	30.33	31.87	33.87	872	-	-	-	-	-	-	44
KENTUCKY	23.58	26.73	31.85	MM	MM	MM	18.40	20.91	24.89	95	X	X	X	X	X	X	14
LOUISIANA	54.98	56.20	61.15	MM	MM	MM	53.12	53.12	53.12	108	-	X	X	X	X	X	39
MAINE	29.30	31.52	36.14	MM	MM	MM	22.85	24.29	27.63	52	X	X	X	X	X	X	6
MARYLAND 1/	32.71	39.57	41.06	MM	MM	MM	26.27	32.04	31.15	4,250	-	-	-	-	-	-	29
MASSACHUSETTS	29.20	31.50	35.56	MM	MM	MM	32.04	32.04	31.15	5,151	-	-	-	-	-	-	18
MICHIGAN 1/	32.87	38.25	44.81	MM	MM	MM	24.31	27.05	27.05	6,576	-	-	-	X	X	X	33
MINNESOTA	24.33	25.59	28.79	MM	MM	MM	19.68	22.11	23.30	7,312	-	-	-	X	X	X	11
MISSISSIPPI	25.01	34.05	37.13	MM	MM	MM	19.98	20.50	30.01	2,379	-	-	-	-	-	-	41
MISSOURI	30.20	33.85	36.75	MM	MM	MM	20.39	21.22	24.10	132	-	-	-	-	-	-	25
MONTANA	30.35	35.45	38.22	MM	MM	MM	25.88	29.88	31.07	4,577	-	-	-	-	-	-	27
NEBRASKA	30.15	37.72	40.25	MM	MM	MM	25.99	31.27	32.65	82	-	-	-	X	X	X	24
NEVADA 2/	MM	MM	MM	MM	MM	MM	28.37	33.22	33.22	204	-	-	-	-	-	-	20
NEW HAMPSHIRE	38.73	43.05	46.13	MM	MM	MM	31.56	34.57	36.36	52	-	-	-	-	-	-	X
NEW JERSEY	MM	MM	MM	MM	MM	MM	MM	MM	MM	404	-	-	-	X	-	-	10
NEW MEXICO	46.70	56.28	66.31	MM	MM	MM	35.76	40.50	44.59	452	-	-	-	-	-	-	27
NEW YORK	57.54	62.68	67.63	MM	MM	MM	25.88	29.88	31.07	79	-	-	-	-	-	-	24
N CAROLINA	31.25	34.19	41.40	MM	MM	MM	26.56	28.90	34.81	206	-	-	-	X	X	X	20
N DAKOTA	26.44	31.91	36.33	MM	MM	MM	21.42	24.46	30.51	30	-	-	-	-	-	-	X
OHIO	30.56	36.81	38.56	MM	MM	MM	21.56	24.46	30.51	27	-	-	-	-	-	-	10
OKLAHOMA	21.00	26.00	29.00	MM	MM	MM	27.31	29.06	32.83	404	-	-	-	-	-	-	4
OREGON	28.61	34.23	39.79	MM	MM	MM	22.03	25.89	29.06	18,299	-	-	-	X	X	X	3
PENNSYLVANIA	36.43	40.85	47.32	MM	MM	MM	25.89	29.06	32.83	1,855	-	-	-	X	X	X	17
RHODE ISLAND	35.29	39.84	44.25	MM	MM	MM	26.91	29.43	31.76	2,011	-	-	-	X	X	X	28
S CAROLINA 1/	MM	MM	MM	MM	MM	MM	MM	MM	MM	662	-	-	-	X	X	X	23
S CAROLINA 2/	MM	MM	MM	MM	MM	MM	MM	MM	MM	7,579	-	-	-	X	X	X	23
TENNESSEE	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	40
TEXAS	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	21
UTAH	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	X
VERMONT	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	9
VIRGINIA	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	13
WASHINGTON	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	MM
WEST VIRGINIA	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	MM
WISCONSIN	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	MM
WYOMING	MM	MM	MM	MM	MM	MM	MM	MM	MM	MM	-	-	-	-	-	-	MM

TABLE C-1
SNF REIMBURSEMENT RATES

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA										ANCILLARY SERVICES INCLUDED							State Rank, by Average Rate (FY81)
	AVERAGE RATE PER PATIENT DAY (1)			AVERAGE MEDICAID PAYMENT PER PATIENT DAY (2)			TOTAL DAYS OF CARE (in thousands)				IN PER DIEM RATE							
	FY79	FY80	FY81	FY79	FY80	FY81	FY79	FY80	FY81	PI	OT	Non-Legend Drugs	Prescribed Drugs	Medical Supplies	Durable Equipment	Other		
S DAKOTA	20.94	25.33	26.36	16.35	17.79	19.74	160	150	150	X	X	X	X	X	X	X	-	
TENNESSEE	32.80	36.20	40.50	31.12	33.17	36.24	123	235	306	X	X	X	X	X	X	X	-	
TEXAS	28.68	33.67	36.95	22.69	24.48	26.28	1,645	1,637	1,423	X	X	X	X	X	X	X	-	
UTAH	32.30	36.52	39.32	26.53	29.20	30.40	392	316	225	-	-	X	X	X	X	-	8	
VERMONT	35.98	41.95	47.77	30.68	35.48	41.51	33	31	20	X	X	X	X	X	X	X	-	
VIRGINIA	62.54	46.43	51.26	38.13	41.98	45.47	192	227	276	X	X	X	X	X	X	X	-	
WASHINGTON 1/	27.83	30.24	34.37	MM	MM	26.00	16	16	16	-	-	-	-	-	-	-	-	
W VIRGINIA 2/	30.27	33.79	36.88	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	X	-	
WISCONSIN 3/	35.00	38.00	42.00	30.00	33.00	36.00	6,100	6,500	6,900	X	X	X	X	X	X	X	-	
WYOMING 4/	26.30	29.90	33.71	18.35	20.04	23.14	378	408	426	X	X	X	X	X	X	-	-	
TOTAL STATES											25	22	39	6	42	33	9	
SIMPLE AVERAGE	33.52	37.49	41.71	25.70	28.94	32.24	2,729	2,771	2,627									

MM Indicates Data Not Reported or Not Available

- 1/ Days of care combined with ICF for 1981.
- 2/ Rates for dual facilities.
- 3/ Data for comprehensive care facilities.
- 4/ Days of care combined with ICF for 1980.
- 5/ Data not confirmed by State.
- 6/ Days of care combined with ICF.
- 7/ Data reported is composite of all long-term care facilities.
- 8/ SNF dually certified - rates average for April-September.
- 9/ Days of care combined with ICF.

TABLE C-2

ICF REIMBURSEMENT RATES

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA										ANCILLARY SERVICES INCLUDED								State Rank by Average Rate (FY81)
	AVERAGE RATE PER PATIENT DAY (\$)		PER PATIENT DAY (\$)		TOTAL DAYS OF CARE (in thousands)		IN PER DIEM RATE		IN PER DIEM RATE		ANCILLARY SERVICES INCLUDED								
	FY79	FY80	FY81	FY79	FY80	FY81	FY79	FY80	FY79	FY80	PT	OT	Non-Legend Drugs	Legend Drugs	Medical Supplies	Durable Equipment	Other		
ALABAMA	18.67	22.04	24.20	22.63	22.75	22.63	5,412	5,461	5,718		X	X	X	X	X	X	X	-	
ALASKA 1/	84.97	93.45	97.39	MM	MM	MM	4	4	4		X	X	X	X	X	X	X	-	
ARKANSAS	19.17	22.45	24.65	16.46	18.16	19.53	2,879	3,077	3,168		X	X	X	X	X	X	X	-	
CALIFORNIA 2/	MM	MM	28.98	26.44	30.58	32.31	1,113	2,176	2,215		X	X	X	X	X	X	X	-	
COLORADO	23.62	25.66	28.24	17.49	19.80	20.91	2,530	2,061	2,788		X	X	X	X	X	X	X	-	
CONNECTICUT	22.67	24.16	26.57	17.62	18.29	19.55	900	922	949		X	X	X	X	X	X	X	-	
DELAWARE	32.30	34.31	44.28	34.86	36.98	36.62	323	371	434		X	X	X	X	X	X	X	-	
DIST. COLUMBIA	38.09	50.55	50.87	32.53	44.38	44.02	230	299	383		X	X	X	X	X	X	X	-	
FLORIDA	25.52	28.48	MM	18.15	20.46	22.61	4,202	4,773	5,546		X	X	X	X	X	X	X	-	
GEORGIA 3/	21.73	23.56	26.17	17.24	18.78	20.58	5,579	5,552	5,521		X	X	X	X	X	X	X	-	
HAWAII	43.21	49.34	58.18	39.23	42.96	50.28	269	307	420		X	X	X	X	X	X	X	-	
IDAHO	23.96	27.57	29.63	19.42	21.39	27.38	577	629	626		X	X	X	X	X	X	X	-	
ILLINOIS	19.07	20.67	22.84	14.16	15.17	16.38	13,332	13,318	13,332		MM	MM	MM	MM	MM	MM	MM	-	
INDIANA	MM	MM	MM	MM	MM	MM	MM	MM	MM		MM	MM	MM	MM	MM	MM	MM	-	
IOWA	20.00	22.15	24.00	15.20	15.90	16.75	5,600	5,700	5,800		MM	MM	MM	MM	MM	MM	MM	-	
KANSAS	17.42	19.99	22.16	13.25	14.66	16.01	4,134	4,210	4,297		X	X	X	X	X	X	X	-	
KENTUCKY	22.95	21.89	27.66	18.28	20.71	21.93	2,836	3,356	3,806		X	X	X	X	X	X	X	-	
LOUISIANA	21.40	24.43	26.62	16.66	18.93	20.58	5,741	6,530	6,601		X	X	X	X	X	X	X	-	
MAINE	30.13	33.50	37.05	MM	MM	29.15	2,321	2,510	2,438		X	X	X	X	X	X	X	-	
MARYLAND 4/	29.30	31.52	36.14	22.85	24.29	27.63	3,823	4,250	4,527		X	X	X	X	X	X	X	-	
MASSACHUSETTS	23.32	26.22	29.15	17.69	21.55	21.39	6,520	6,119	6,019		X	X	X	X	X	X	X	-	
MICHIGAN 5/	27.30	29.56	32.52	MM	MM	MM	5,351	11,673	8,974		X	X	X	X	X	X	X	-	
MINNESOTA	26.70	30.91	35.88	MM	MM	MM	5,109	5,268	5,210		X	X	X	X	X	X	X	-	
MISSISSIPPI	21.75	21.33	24.97	19.00	20.15	22.09	881	1,355	1,821		X	X	X	X	X	X	X	-	
MISSOURI	22.31	26.82	29.64	17.72	21.35	23.03	4,210	4,696	5,378		X	X	X	X	X	X	X	-	
MONTANA	30.20	33.85	36.75	22.04	24.35	26.86	1,212	1,277	1,355		X	X	X	X	X	X	X	-	
NEBRASKA	18.69	20.55	22.57	14.84	16.12	17.43	2,563	2,524	2,566		X	X	X	X	X	X	X	-	
NEVADA 6/	29.54	36.25	39.03	26.54	29.55	30.74	321	540	595		X	X	X	X	X	X	X	-	
N. HAMPSHIRE 1/	MM	34.69	40.68	MM	MM	31.87	MM	1,394	1,490		X	X	X	X	X	X	X	-	
NEW JERSEY	33.28	36.38	39.48	26.72	28.75	30.49	6,458	6,585	6,670		X	X	X	X	X	X	X	-	
NEW MEXICO	24.23	26.74	30.20	19.60	21.74	24.30	667	719	797		X	X	X	X	X	X	X	-	
NEW YORK	36.18	39.66	42.74	MM	MM	MM	7,006	7,280	7,335		X	X	X	X	X	X	X	-	
N. CAROLINA	24.78	26.82	29.91	20.19	21.59	23.62	2,674	3,073	3,281		X	X	X	X	X	X	X	-	
N. DAKOTA	20.03	23.56	27.35	16.11	17.94	21.99	514	544	583		X	X	X	X	X	X	X	-	
OHIO	23.16	31.61	33.62	MM	MM	MM	5,271	6,095	7,561		X	X	X	X	X	X	X	-	
OKLAHOMA	28.00	22.50	28.00	MM	MM	20.99	MM	MM	6,206		X	X	X	X	X	X	X	-	
OREGON	23.75	27.29	30.28	17.16	19.51	21.01	2,629	2,774	2,840		X	X	X	X	X	X	X	-	
PENNSYLVANIA 8/	MM	MM	MM	24.22	27.61	33.88	4,434	4,591	4,591		X	X	X	X	X	X	X	-	
RHODE ISLAND	27.26	30.60	34.99	23.33	23.79	26.95	1,870	2,079	2,105		X	X	X	X	X	X	X	-	
S. CAROLINA 3/	27.16	30.04	33.28	26.91	29.43	31.76	2,704	3,027	3,119		X	X	X	X	X	X	X	-	

TABLE C-2

ICF REIMBURSEMENT RATES

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA						ANCILLARY SERVICES INCLUDED							State Rank, by Average Rate (FY81)
	AVERAGE RATE PER PATIENT DAY (\$)			AVERAGE MEDICAID PAYMENT PER PATIENT DAY (\$)			IN PER DIEM RATE							
	FY79	FY80	FY81	FY79	FY80	FY81	PT	OT	Non-Legend Drugs	Legend Drugs	Medical Supplies	Durable Equipment	Other	
S DAKOTA	19.15	21.43	23.91	14.77	16.36	17.61	X	X	X	X	X	X	-	44
TENNESSEE	22.90	25.30	27.40	16.70	19.58	20.32	X	X	X	-	X	X	-	35
TEXAS	22.94	26.06	27.61	15.61	17.69	18.66	-	-	X	X	X	X	-	34
UTAH	26.94	28.77	34.02	22.15	22.56	26.24	-	-	X	X	X	-	-	17
VERMONT	29.64	32.45	35.65	23.92	25.85	27.85	X	X	X	-	X	X	-	14
VIRGINIA	30.88	35.10	38.19	24.83	27.34	29.76	X	X	X	-	X	X	-	9
WASHINGTON 10/	27.83	30.24	34.37	MM	MM	26.00	-	-	-	-	-	-	-	16
W VIRGINIA	24.98	27.83	30.57	MM	MM	MM	X	X	X	-	X	X	-	23
WISCONSIN	27.08	29.00	32.00	23.00	25.00	27.00	X	X	X	X	X	X	-	22
WYOMING 11/	26.30	29.90	33.71	18.35	20.04	23.14	X	X	X	-	X	-	-	18
TOTAL STATES							27	24	41	8	44	35	9	
SIMPLE AVERAGE	26.79	30.20	33.49	20.74	23.16	25.31								

MM Indicates Data Not Reported or Not Available

1/ Days of care combined with SNF for 1981

2/ Days of care combined with ICF-MR for 1980 and 1981.

3/ 1981 Rates in effect Jan-Oct 1981.

4/ Data for Comprehensive Care Facilities.

5/ Days of care combined with SNF for 1980.

6/ Data not confirmed by State.

7/ Ancillaries: PT only if in-house personnel and equipment; Prescribed Drugs only if in-house pharmacy.

8/ Ancillaries included in per diem for non-hospital based homes.

9/ Days of care combined with SNF.

10/ Data reported is composite of all long-term care facilities.

11/ Days of care combined with SNF.

TABLE C-3

ICF-MR REIMBURSEMENT RATES

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA										ANCILLARY SERVICES INCLUDED							State Rank, by Average Rate (FY61)
	AVERAGE RATE PER PATIENT DAY (\$)		AVERAGE MEDICAID PAYMENT PER PATIENT DAY (\$)		TOTAL DAYS OF CARE (in thousands)		IN PER DIEM RATE											
	FY59	FY60	FY61	FY59	FY60	FY61	FY59	FY60	FY61	PI	QI	Non-Legend Drugs	Prescribed Drugs	Medical Supplies	Durable Equipment	Other		
ALABAMA	58.21	74.20	94.10	MM	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	5	
ALASKA	145.00	153.00	167.00	MM	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	1	
ARKANSAS	32.35	36.54	64.55	25.96	32.23	55.42	591	560	523	X	X	X	X	X	X	X	18	
CALIFORNIA 1/	35.17	49.61	55.86	26.44	30.58	32.31	937	2,176	2,215	X	X	X	X	X	X	X	25	
COLORADO				34.92	49.26	55.47	605	604	559									
CONNECTICUT	MM	MM	MM	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	X	X	
DELAWARE	35.39	43.49	48.46	36.31	42.19	46.02	155	154	161	X	X	X	X	X	X	X	30	
DIST. COLUMBIA	66.14	66.23	65.63	63.50	64.49	63.99	200	143	87	X	X	X	X	X	X	X	16	
FLORIDA	MM	MM	MM	44.49	51.96	58.05	298	487	519	X	X	X	X	X	X	X	X	
GEORGIA	61.72	69.63	84.12	60.09	67.90	82.16	375	579	574	X	X	X	X	X	X	X	7	
HAWAII	61.20	69.57	83.55	MM	67.91	81.41	159	149	138	X	X	X	X	X	X	X	8	
IDAHO	46.92	50.38	73.49	46.01	50.17	72.77	159	143	148	X	X	X	X	X	X	X	11	
ILLINOIS	19.28	21.42	24.62	16.31	18.11	20.78	923	938	946	MM	MM	MM	MM	MM	MM	MM	39	
INDIANA	MM	MM	MM	MM	MM	MM	MM	MM	675								17	
IOWA	58.00	60.00	65.00	55.75	56.50	60.50	600	640		X	X	X	X	X	X	X		
KANSAS	28.78	32.20	34.32	24.61	26.87	28.17	153	205	219	X	X	X	X	X	X	X	35	
KENTUCKY	54.05	52.29	70.97	50.74	59.00	65.42	403	419	473	X	X	X	X	X	X	X	13	
LOUISIANA	35.62	42.18	56.00	33.99	40.46	53.94	755	784	992	X	X	X	X	X	X	X	24	
MAINE 2/	MM	MM	MM	MM	MM	MM	MM	MM	229	X	X	X	X	X	X	X	14	
MARYLAND	61.59	96.72	114.95	MM	MM	MM	537	578	630	X	X	X	X	X	X	X	4	
MASSACHUSETTS	86.00	111.00	123.00	85.00	110.00	122.00	1,400	1,100	1,000	X	X	X	X	X	X	X	2	
MICHIGAN	MM	MM	MM	69.65	MM	MM	1,578	1,587	1,587	X	X	X	X	X	X	X	3	
MINNESOTA	32.87	38.39	45.00	MM	MM	MM	1,081	1,190	1,369	X	X	X	X	X	X	X	33	
MISSISSIPPI	33.82	35.35	38.94	30.53	35.10	36.08	267	259	304	X	X	X	X	X	X	X	36	
MISSOURI	39.91	58.44	71.84	37.74	55.00	68.74	476	547	554	X	X	X	X	X	X	X	12	
MONTANA	46.20	52.97	57.45	15.29	22.54	30.17	24	8	3	X	X	X	X	X	X	X	23	
NEBRASKA	38.46	47.03	55.20	35.51	44.19	57.34	281	331	287	X	X	X	X	X	X	X	26	
NEVADA 3/	37.67	62.39	76.65	37.03	61.02	74.84	49	58	58	X	X	X	X	X	X	X	10	
NEW HAMPSHIRE	MM	MM	MM	MM	MM	MM	MM	MM	111	X	X	X	X	X	X	X	35	
NEW JERSEY	41.12	62.01	65.74	40.29	59.59	62.75	2,344	1,860	1,742	X	X	X	X	X	X	X	15	
NEW MEXICO	49.62	57.71	59.66	34.83	43.80	55.59	132	143	152	X	X	X	X	X	X	X	21	
NEW YORK	MM	MM	MM	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	X	6	
N. CAROLINA	60.44	70.27	84.41	58.44	68.54	82.35	513	635	702	X	X	X	X	X	X	X	1	
N. DAKOTA	MM	MM	MM	MM	MM	MM	MM	MM	693	X	X	X	X	X	X	X	34	
OHIO	30.10	42.20	44.59	MM	MM	MM	368	464		X	X	X	X	X	X	X		
OKLAHOMA	46.15	46.15	60.00	MM	MM	MM	MM	MM	651	X	X	X	X	X	X	X	21	
OREGON	51.25	52.38	57.73	39.13	MM	MM	107	MM	MM	X	X	X	X	X	X	X	22	
PENNSYLVANIA	MM	MM	MM	76.86	87.03	98.94	2,323	2,415	2,653	X	X	X	X	X	X	X	22	
RHODE ISLAND	26.23	35.36	50.15	23.32	31.90	46.26	32	59	73	X	X	X	X	X	X	X	29	
S. CAROLINA	44.31	53.08	54.75	41.38	43.84	46.03	455	596	734	X	X	X	X	X	X	X	29	

TABLE C-3

ICF-MR REIMBURSEMENT RATES

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA										ANCILLARY SERVICES INCLUDED						State Rank by Average Rate (FY81)
	AVERAGE RATE PER PATIENT DAY (\$)			AVERAGE MEDICAID PAYMENT PER PATIENT DAY (\$)			TOTAL DAYS OF CARE (in thousands)				IN PER DIEM RATE						
	FY79	FY80	FY81	FY79	FY80	FY81	FY79	FY80	FY81	PT	OT	Non-Legend Drugs	Prescribed Drugs	Medical Supplies	Durable Equipment	Other	
SDAKOTA	MM	MM	MM	38.99	45.38	51.02	243	239	232	X	X	X	X	X	X	X	X
TENNESSEE	MM	MM	MM	49.88	55.54	60.61	649	731	817	X	X	X	X	X	X	X	X
TEXAS	32.27	41.71	47.71	35.89	41.43	44.43	3,443	3,956	4,322	-	-	-	-	X	X	-	32
UTAH	44.06	41.64	48.22	42.56	39.22	45.32	421	438	427	-	-	-	-	X	X	-	31
VERMONT	48.00	65.01	81.67	45.96	62.64	79.12	141	148	136	X	X	X	X	X	X	-	9
VIRGINIA	32.35	42.86	50.19	30.22	40.42	47.40	1,292	1,341	1,489	X	X	X	-	X	X	-	28
WASHINGTON 4/	27.83	30.24	34.37	MM	MM	26.00	16	16	16	-	-	-	-	-	-	-	31
W VIRGINIA	MM	MM	MM	MM	MM	MM	MM	MM	MM	X	X	X	X	X	X	-	X
WISCONSIN	50.00	55.00	61.00	47.00	52.00	58.00	800	800	800	X	X	X	X	-	X	X	19
WYOMING 5/	0.00	0.00	0.00	0.00	0.00	0.00	0	0	0	-	-	-	-	-	-	-	X
TOTAL STATES	47.17	55.50	66.64	42.21	49.56	57.27	637	689	714	26	23	39	8	41	33	9	
SIMPLE AVERAGE																	

MM Indicates Data Not Reported or Not Available

1/ Days of care combined with ICF for 1980 and 1981.

2/ ICF-MRs implemented 7/81-80.

3/ Data not confirmed by State.

4/ Data reported is composite of all long-term care facilities.

5/ ICF-MR not provided.



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